NAME: DOB: NHS NO:

Physiotherapy Self-Referral Form **Referral Date: 11/01/2018**

Prior to completing this form please be advised that you **must be 18 years or older** and seeking help with a **musculoskeletal problem,** such as neck or back pain, soft tissue or joint problems such as strains and sprains. We will only accept a self-referral for **one** problem. We **cannot accept a repeat referral** for the same problem within **6 months after discharge** from our physiotherapy services.

It is important you do no self-refer if you have any of the following conditions without consulting your GP first: Unexplained weight loss, unexplained bladder or bowel problems, history of cancer, night pain, fever or night sweats, unsteady on feet, pins and needles/numbness in both arms or legs, pregnancy, respiratory problems, central chest pain, abdominal pain, neurological problems or symptoms of vertigo.

PATIENT DETAILS

Surname	First Name	Gender	Date of Birth
Address		Post Code	NHS Number
Home Tel Tick Preferred: ☐		Can we leave message? Yes ☐ No ☐	
Mobile Tel ☐		Can we send text messages for appointments? Yes ☐ No ☐	
Work Tel ☐		Is an interpreter required? Yes ☐ No ☐	
E-Mail		If yes, what language?	

GP DETAILS

GP Name	Have you consulted your GP about this problem?
	Yes ☐ No ☐
GP Details	Did the GP suggest being referred to Physiotherapy?
	Yes ☐ No ☐
Tel No	Do you consent to us contacting your GP if appropriate?
	Yes ☐ No ☐
	Are you seeing anyone else about this problem? *Eg Orthopaedic Consultant*
	Yes ☐ No ☐

REFERRAL DETAILS

Where is the problem?	Is the problem new?
Neck	New
When did the problem start?	Are your symptoms getting worse?
Less than 2 weeks	Yes ☐ No ☐
How did it happen?	
Gradually Details	

NAME: DOB: NHS NO:

What symptoms do you have and where are they? E.g *Pain, stiffness, pins and needles, numbness, weakness / Right side of neck, Outside of left hip, Under both heels*
Details

Are you off work because of this problem?	Are you unable to care for a dependant because of this problem?
Yes	Yes ☐ No ☐
Are you able to carry out your normal activities?	**Have you had a recent operation relating to this problem?**
Yes ☐ No ☐	Yes ☐ No ☐

Have you had any investigations for this problem? *E.g. X-ray, MRI, Blood test*
Details

Have you had any previous treatment for this condition? *E.g. Medical treatment, Physiotherapy, Osteopathy, Chiropractic*
Details

Do you have any other medical conditions, which may be relevant to your problem? *Please tick which apply and elaborate below, add anything else you feel might be relevant below*		
Heart Problems ☐	Osteoporosis ☐	History of Cancer ☐
Pacemaker ☐	Rheumatoid Arthritis ☐	Sudden weight loss ☐
Epilepsy ☐	Other joint problems/injuries ☐	Fever or night sweats ☐
Diabetes ☐	Surgery/Operations ☐	Allergies ☐
Details		

Do you require a Physiotherapist of the same sex?	Would a telephone appointment be sufficient?
Yes ☐ No ☐ ( )	Yes ☐ No ☐

Please select a preferred clinic for your appointment: (Generally available between 08:00 and 16:30)		
Addison House Community Clinic, Harlow ☐	St Margaret's Hospital, Epping ☐	Rectory Lane Health Centre, Loughton (Mon/Fri Only) ☐
Waltham Abbey Health Centre, Waltham Abbey (Tue/Thu Only) ☐	Herts and Essex Hospital, Bishop's Stortford ☐	Saffron Walden Community Hospital, Saffron Walden ☐

Do you consent to **us sharing your records with other users** such as GP Surgeries and Community Health Services within the NHS through the computer system SystmOne? Yes ☐ No ☐

Do you consent to **other services** such as GP Surgeries or Community Health Services within the NHS **sharing your records with us** through the computer system SystmOne? Yes ☐ No ☐

IF YOUR REFERRAL IS FOR YOUR **LOWER BACK** THEN PLEASE FILL FORM ON NEXT PAGE

OTHERWISE SCROLL TO BOTTOM OF NEXT PAGE AND SEE HOW TO SEND FORM

NAME: DOB: NHS NO:

KEELE START BACK SCREENING TOOL

If you have self-referred for a **lower back** complaint then you must fill in this form to avoid your referral being rejected.

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	Agree 1
1	My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
2	I have had pain in the **shoulder or neck** at some time in the last 2 weeks	☐	☐
3	I have only **walked short distances** because of my back pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7	I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8	In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9 Overall, how **bothersome** has your back pain been in the **last 2 weeks**?				
Not at all 0 ☐	Slightly 0 ☐	Moderately 0 ☐	Very much 1 ☐	Extremely 1 ☐

Total Score:

Sub Score (Q5-Q9):

*****SENDING FORM*****

EMAIL

PLEASE NOTE THAT INFORMATION SENT BY EMAIL IS NOT SECURE. THIS MEANS THERE IS A RISK OF IT BEING INTERCEPTED BY PEOPLE OTHER THAN THOSE IT WAS INTENDED FOR

Please save form and send as an attachment to mskphysio.sept@nhs.net

POST

If you are unable to or do not wish to send by e-mail then please print form and post to the hospital closest to you:

Physiotherapy Department, St Margaret's Hospital, The Plain, Epping, Essex, CM16 6TN

OR

Physiotherapy Department, Herts and Essex Hospital, Haymeads Lane, Bishop's Stortford, Herts, CM23 5JH

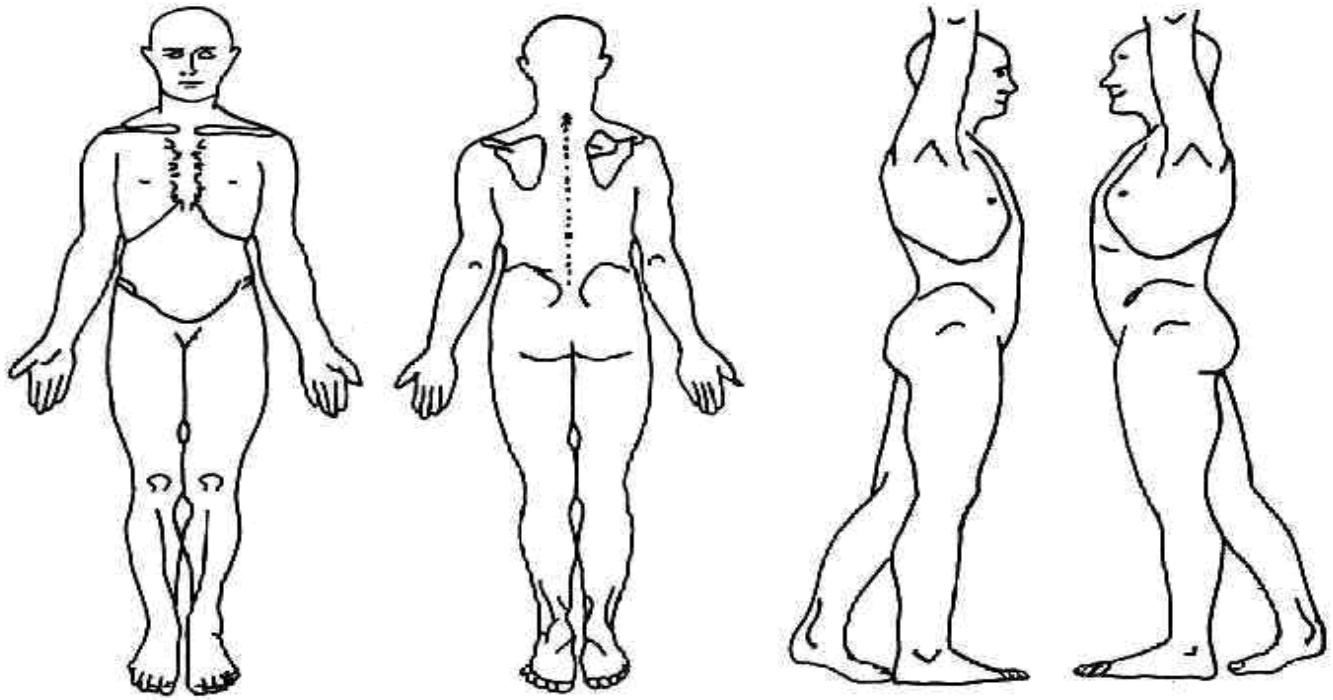
If you have any queries please contact our central booking service on 01279 827404

****Physiotherapist Use Only****

Triage Comments:

*****PHYSIOTHERAPIST USE ONLY*****

NAME: DOB: NHS NO:



Numbness	☐
Bowel	☐
Bladder	☐
Saddle anaesthesia	☐
Leg weakness	☐

Numbness	☐
Nausea	☐
Nystagmus	☐
Ataxia	☐
Drop Attacks	☐
Dizziness	☐
Diplopia	☐
Dysphasia	☐
Dysarthria	☐

0 ——————————— 10

Aggs:

Eases:

24hr Pattern:

S –

I –

N –

Treatment Plan:

Goals: