|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | |  | | | | | | | |
| **MUSCULOSKELETAL PHYSIOTHERAPY OUTPATIENT SERVICES** | | | | | | | | | | | |
| **PART ONE: Screening form for Self-Referral** | | | | | | | | | | | |
| PLEASE COMPLETE THIS CHECKLIST TO SEE IF YOU ARE SUITABLE FOR SELF REFERRAL TO PHYSIOTHERAPY | | | | | | | | | | | |
| 1. Were you given this form by a health professional: GP, physiotherapist, or nurse?   **If no, please contact your local GP surgery** where you will be directed to the most appropriate physiotherapy service.  NB: If you are a Courtyard Surgery patient, please continue to use this form. | | | | | | | | | YES 🞎 NO 🞎 | | |
| 2. Are you under 16 years old? | | | | | | | | | YES 🞎 NO 🞎 | | |
| 3. Are you filling in this form on behalf of someone else? | | | | | | | | | YES 🞎 NO 🞎 | | |
| 4. Has your general health changed recently in any way that you haven’t discussed with your GP? | | | | | | | | | YES 🞎 NO 🞎 | | |
| 5. Have you had a significant accident recently, for which you have not sought medical advice? | | | | | | | | | YES 🞎 NO 🞎 | | |
| 6. Is this problem to do with; | | | | | | | | |  | | |
| * Your breathing/chest | | | | | | | | | YES 🞎 NO 🞎 | | |
| * A neurological problem e.g., stroke or multiple sclerosis | | | | | | | | | YES 🞎 NO 🞎 | | |
| * Incontinence | | | | | | | | | YES 🞎 NO 🞎 | | |
| 7. If you have back pain: since the pain came on have you developed any of the following symptoms: | | | | | | | | |  | | |
| * Problems passing urine | | | | | | | | | YES 🞎 NO 🞎 | | |
| * Problems controlling bowel movements | | | | | | | | | YES 🞎 NO 🞎 | | |
| * Pins and needles or numbness between your legs or around your back passage | | | | | | | | | YES 🞎 NO 🞎 | | |
| **If you have answered yes to any of the questions 2-7 above, you are not suitable to self-refer to physiotherapy.** Please contact your GP practice to find out who is the best person to speak to or see regarding your problem/condition. | | | | | | | | | | | |
| Otherwise, please answer the questions below and proceed to PART TWO | | | | | | | | | | | |
| **Consent to Data Sharing**  Do you consent to information recorded by us being shared with other health  care professionals? YES 🞎 NO 🞎  Do you consent to this organisation viewing data relating to your care held  on other GP systems? (GP, Out of hours, etc) YES 🞎 NO 🞎  From your records we will triage your referral. We may call you for more information if it is felt appropriate. | | | | | | | | | | | |
| **Signed:…………………………………… Date:………………………………………** | | | | | | | | | | |
|  | | |  | | | | | | | |
| **MUSCULOSKELETAL PHYSIOTHERAPY OUTPATIENT SERVICES** | | | | | | | | | | |
| **PART TWO: Patient details for Self-Referral – PLEASE COMPLETE EVERY SECTION** | | | | | | | | | | |
| **INCOMPLETE OR ILLEGIBLE FORMS WILL NOT BE ACCEPTED** | | | | | | | | | | |
| Date |  | NHS Number (if known) | | |  | | | | | |
| Surname |  | Forename(s) | | |  | | | | | |
| Previous Surname |  | Title (eg Mr, Mrs) | | |  | | | Sex (M/F) | |  |
| Date of Birth |  | Daytime Tel No | | |  | | | | | |
| Address |  | Mobile No | | |  | | | | | |
| Can we leave a message via voicemail or text message: YES 🞎 NO 🞎 | | | | | | | | |
| Email | | |  | | | | | |
| Post code |  | GP practice | | |  | | | | | |
| Please give us a brief description of where your problem is: | | | | | | | | | | |
| How long have you had these symptoms? | | | | | | | | | | |
| Were these symptoms: Gradual: 🞎 Sudden: 🞎 | | | | | | | | | | |
| Have you attended physiotherapy for the same condition in the last 6 months? | | | | | | YES 🞎 NO 🞎 | | | | |
| Have you had any other treatments for this problem? (Include dates) | | | | | | | | | | |
| Is your problem worsening? | | | | | | | YES 🞎 NO 🞎 | | | |
| Are you able to continue your normal activities? | | | | | | | YES 🞎 NO 🞎 | | | |
| Is this problem preventing you from working? | | | | | | | YES 🞎 NO 🞎 | | | |
| Do you have any pins and needles or numbness? | | | | | | | YES 🞎 NO 🞎 | | | |
| Is this problem waking you at night? | | | | | | | YES 🞎 NO 🞎 | | | |
| When you have completed PART TWO please send to us by:  **Post**: Physiotherapy Central Booking Department, Chippenham Community Hospital, Rowden Hill, Chippenham, SN15 2AJ  **Email**: [whc.mskphysiobookingcentre@nhs.net](mailto:whc.mskphysiobookingcentre@nhs.net)  **By hand**: To your local physiotherapy department or to your GP practice who will put in internal post on your behalf.  **CONFIRMATION: If you have not received confirmation of your referral within 3 working days.  Please contact 01249 456515. This will be longer for postal referrals.** | | | | | | | | | | |