OUT-PATIENT PHYSIOTHERAPY – SELF REFERRAL FORM for patients aged 16 & over
Referrals may be rejected if incomplete or illegible.
Please use block capitals and black ink

Full name (Mr/Mrs/Miss/Ms)	**NHS Number :**
Address: **Postcode:**	**Date of Birth :**
Day time contact number:	**Today's Date:**

Which GP practice are you registered at?

How did you hear about the self-referral service? (please circle as appropriate)

GP advised me to refer
Heard about the service from a friend
Saw poster in waiting room
Other (please state) ……

Have you seen your GP or another healthcare professional e.g. practice nurse about this problem?

Yes No

What area of your body is affected?

Please list any investigations and results you have had for this condition below

……
……

Please describe your problem? (e.g. pain/aching/stiffness/swelling)

How long have you had this problem?

Less than 2 weeks | 2 – 4 weeks | More than 4 weeks | More than 1 year

Is this problem?

New | Flare up of old problem | On-going long term problem

Is your problem?

Getting better | Getting worse | Staying same

Are you off work because of this problem?

Yes | No | Not applicable

IF OFF work HOW LONG have you been off? (e.g. 2 weeks)

Is your sleep disturbed by this problem?

Yes | No

Have you had physiotherapy for this problem within the last 6 months?
Yes No

MEDICAL CONDITIONS	MEDICATION

If you have any of the following please see your GP before referring yourself to physiotherapy:

- **Significant Trauma**
- **You are feeling generally unwell**
- **Changes in your bladder or bowel habits**
- **Have single of multiple hot swollen joints**
- **Constant or severe pain that you are unable to find relief**
- **Weakness, pins and needles, loss of feeling**
- **Unexpected weight loss**

To refer yourself it is important that you complete the form as fully as possible. Please note we cannot take responsibility for any information that has been withheld.

The information you provide will be shared with your GP or other relevant healthcare professional.

Do you give consent for the physiotherapy department to correspond with your GP if required? YES / NO (please circle)

Signature ……. Date …….

Please return your completed form to your GP reception