

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:	NHS Number :
Address:	Date of Birth:
	Postcode:
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 <input type="checkbox"/> Heard about the service from a friend <input type="checkbox"/> Saw poster in waiting room <input type="checkbox"/> Other (please state)	
Have you seen your GP or another healthcare professional e.g. practice nurse about this problem?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> More than 4 weeks <input type="checkbox"/> More than 1 year <input type="checkbox"/>	
Is this problem?	
New <input type="checkbox"/> Flare up of old problem <input type="checkbox"/> On-going long term problem <input type="checkbox"/>	
Is your problem?	
Getting better <input type="checkbox"/> Getting worse <input type="checkbox"/> Staying same <input type="checkbox"/>	
Are you off work because of this problem?	
Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/>	
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 or 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 this 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 professionals.

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

Signature

Date:

Please return your completed form to your GP reception.