|  **MUSCULOSKELETAL PHYSIOTHERAPY OUTPATIENT SERVICES** |
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| **PART ONE: Screening form for Self-Referral** |
| PLEASE COMPLETE THIS CHECKLIST TO SEE IF YOU ARE SUITABLE FOR SELF REFERRAL TO PHYSIOTHERAPY |
| 1. Are you under 16 years old? | YES [ ]  NO [ ]  |
| 2. Are you filling in this form on behalf of someone else? | YES [ ]  NO [ ]  |
| 3. Have you attended Physiotherapy for the same condition in the last 6 months? | 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; | YES [ ]  NO [ ]  |
| 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; | YES [ ]  NO [ ]  |
| 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 ABOVE, YOU ARE NOT SUITABLE FOR SELF-REFERRAL TO PHYSIOTHERAPY.** Please contact your GP Practice to find out who the best person is to speak to or see regarding your problem/condition.  |
| If you have answered ‘no’ to all the questions above, then 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 [ ]  |
| **Signed:**       **Date:** <Today's date> |

|  **MUSCULOSKELETAL PHYSIOTHERAPY OUTPATIENT SERVICES** |
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| **PART TWO: Patient details for Self-Referral – PLEASE COMPLETE EVERY SECTION** |
| **INCOMPLETE OR ILLEGIBLE FORMS WILL NOT BE ACCEPTED** |
| Date | <Today's date> | NHS Number  | <NHS number> |
| Surname | <Patient Name> | Forename(s) | <Patient Name> |
| Previous Surnames |       | Title | <Patient Name> | Sex  | <Gender> |
| Date of Birth | <Date of birth> | Daytime Tel No | <Patient Contact Details> |
| Address | <Patient Address> | Mobile No | <Patient Contact Details> |
| Can we leave a message: YES [ ]  NO [ ]  |
| GP Practice  | <GP Details> |
| Post Code  | <Patient Address> |
| **Please give us a brief description of your problems or symptoms:**     <Event Details> |
| **How long have you had these symptoms:**       |
| **Have you had any other interventions or treatments for this problem? (Include dates)**      |
| **Please complete the following questions:** |
| Did your GP suggest you complete this form? | YES [ ]  NO [ ]  |
| 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 [ ]  |
| When you have completed PART TWO please send to us by:**Post to**: Physiotherapy Central Booking Department, Chippenham Community Hospital, Rowden Hill, Chippenham, SN15 2AJ **Or**Physiotherapy Department, Salisbury District Hospital, Salisbury, Wilts. SP2 8BJ**Email**: BSWCCG.routinesarumreferralcentre@nhs.net**By hand**: to your GP Practice or local physiotherapy department who will forward it onto the Physiotherapy Central Booking Department on your behalf. |

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| **Musculoskeletal physiotherapy outpatient services** |
| **PART THREE:****DO NOT COMPLETE UNLESS YOU HAVE LOW BACK PAIN AND/OR SCIATICA****Screening form for self-referral for low back pain and sciatica** |
| PLEASE COMPLETE BOTH SIDES OF THIS FORM IF YOU ARE SELF-REFERRING TO PHYSIOTHERAPY FOR **LOW BACK PAIN OR SCIATICA** |
| Please indicate which service you think you would be most interested in. Our leaflets give more for information on our servicesI would be interested in: | I would be interested in:      |
| **Back Pain Management Classes** |  |
| * Activate Your Back (one-off class)
 | YES [ ]  NO [ ]  |
| * Back class (six week course)
 | YES [ ]  NO [ ]  |
| One-to-One Physiotherapy Appointment | YES [ ]  NO [ ]  |
| Telephone Appointment | YES [ ]  NO [ ]  |

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| **PART FOUR: Screening form for self-referral for low back pain and sciatica** |

