| **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](mailto: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 services  I 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** |

Graphical user interface, application, Word

Description automatically generated