

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. Are you under 16 years old?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Are you filling in this form on behalf of someone else?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Have you attended physiotherapy for the same condition in the last six months?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Has your general health changed recently in any way that you haven't discussed with your GP?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Have you had a significant accident recently, for which you have not sought medical advice?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Is this problem to do with;	
• Your breathing/chest	YES <input type="checkbox"/> NO <input type="checkbox"/>
• A neurological problem e.g. stroke or multiple sclerosis	YES <input type="checkbox"/> NO <input type="checkbox"/>
• Incontinence	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. If you have back pain: since the pain came on have you developed any of the following symptoms;	
• Problems passing urine	YES <input type="checkbox"/> NO <input type="checkbox"/>
• Problems controlling bowel movements	YES <input type="checkbox"/> NO <input type="checkbox"/>
• Pins and needles or numbness between your legs or around your back passage	YES <input type="checkbox"/> NO <input type="checkbox"/>

If you have answered yes to any of the questions 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.

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:.....

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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: YES <input type="checkbox"/> NO <input type="checkbox"/>			
		GP practice			
Post code					

Please give us a brief description of your problems or symptoms:

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 <input type="checkbox"/>	NO <input type="checkbox"/>
Is your problem worsening?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you able to continue your normal activities?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is this problem preventing you from working?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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PART TWO: Patient details for Self-Referral – PLEASE COMPLETE EVERY SECTION

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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

By hand: To your local physiotherapy department or to your GP practice who will put in
internal post on your behalf