|  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; |  |
| * 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; |  |
| * 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 🞎 |
| **Name: …………………………………… NHS no: ………………………………….****Signed:…………………………………… Date:………………………………………**P.T.O. |
| **MUSCULOSKELETAL PHYSIOTHERAPY OUTPATIENT SERVICES** |
| **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 🞎 NO 🞎 |
| 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 🞎 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**: Physiotherapy Department, Salisbury District Hospital, Salisbury, Wilts. SP2 8BJ**Email**: whc.mskphysiobookingcentre@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.P.T.O. |

|  Musculoskeletal physiotherapy outpatient services |
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| **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: |  |
| 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 🞎 |

##  **Name: …………………………………… NHS no: ………………………………….**

##

##  **Date of birth: …………………………… Date:……………………**

P.T.O.

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

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P.T.O.