Wiltshire HEALTH AND CARE

NHS

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

Question	Answer
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 to self-refer 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

Question	Answer
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 ☐	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 Central Booking Department, Chippenham Community Hospital, Rowden Hill, Chippenham, SN15 2AJ
Email: gwh.communityphysiobookingcentre@nhs.net
Fax: 01249 456516
By hand: to your GP Practice or local physiotherapy department who will forward it onto the Physiotherapy Central Booking Department on your behalf.