[DATE]

**Over 16’s:** This service is for **one musculoskeletal condition**, such as muscle and joint pain, sports injuries, back or neck pain, sprains and strains.

**If you are 16 or under**:please contact your GP and they can refer you to the paediatric physiotherapy team as appropriate.

If you do not wish to self-refer, you can still contact your GP for a referral.

Our catchment area is any **GP practice between Littlehampton and Southwick.** For patients **outside** of this area, please go to: <https://www.sussexcommunity.nhs.uk/services/msk-physiotherapy-self-referral.htm>

How do you refer yourself to Physiotherapy?

**Please complete the form in full** - We may send form back to you if we require more information than provided to help us give you the best care. Send it to us at the address below by post, by email OR by dropping it in to your local physiotherapy department.

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| **Return this form by post to your preference of:**   * Physio Dept, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH * Physio Dept, Southlands Hospital, Old Shoreham Road, Shoreham-by-sea, BN43 6TQ * Physio Dept, Littlehampton Health Centre, Fitzalan Road, Littlehampton, BN17 5HG   **OR** by email to:   * [receptionwor.physio@nhs.net](mailto:receptionwor.physio@nhs.net) (Worthing) * [receptionsou.physio@nhs.net](mailto:receptionsou.physio@nhs.net) (Southlands) * [littlehampton.physio@nhs.net](mailto:littlehampton.physio@nhs.net) (Littlehampton)   **NB. Email is not encrypted nor guaranteed to be completely secured.**  **An online version of this form can be found here:**  [**https://www.uhsussex.nhs.uk/services/physiotherapy/physiotherapy-worthing-strichards-southlands/physiotherapy-self-referral/**](https://www.uhsussex.nhs.uk/services/physiotherapy/physiotherapy-worthing-strichards-southlands/physiotherapy-self-referral/) |

What happens once you have contacted us?

A physiotherapist will review the information provided to ensure your complaint is appropriate for physiotherapy. You may receive a telephone call at this stage to clarify any details you provided.

For Information on our data protection policy and how we use your information, please follow the link below:

<https://www.uhsussex.nhs.uk/resources/your-personal-information/>

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| **Title:**  **First Names:**  **Surname:** |  | | **Address:**  **Postcode:** | |  | | | | |
| **Date of Birth**  **GP Name:**  **GP Practice:** |  | | **Daytime Telephone:**  **Mobile Telephone:**  **Email Address:** | | | |  | | |
| **Are you pregnant?** Y / N How many weeks…………? | | | **Have you seen the GP about this complaint? Y / N** | | | | | | |
| **Who is filling out this form?** | | **Myself Other - Relationship to patient:** | | | | | | | |
| **Are you happy for us to leave a voice message or contact you by email? Y / N** | | | | | | | | | |
| **Do you Require an interpreter?**  **Do you have any hearing difficulties?** | | | **Yes No Which language?**  **Yes No** | | | | | | |
| **Preferred time(s) (Please Circle all appropriate)** | | | | 8-10am | | 10-12am | | 12-2pm | 2-5pm |
| **Preferred Day(s) (Mon – Fri)** | | | |  | | | | | |

**Would you be available at the last minute to take a cancellation slot? Yes / No**

**Would you like to receive advice about your condition prior to your first appointment? Yes / No**

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| --- | --- | --- |
| **Where is your problem?** *(write below or indicate on the picture)*  **How did the problem start?**  **When did the problem start?**  Is it now…….. **Better Same Worse** | Pain Score:  body charet /10 | |
| Do you have any Pins and needles or Numbness? Y / N  If so where? | |
| Are you currently signed off work as a result of your problem? **If yes,** how many days off have you had to take? | *Details:* | |
| Are you the main carer for friend / family member? **If yes,** is this role currently affected by your pain / symptoms? | *Details:* | |
| **Have you had any treatment for this condition recently or for a previous episode? Y / N**  **Did it help? Y / N** please give details: | | |
| **Have you had any recent investigations for this problem?** (i.e. X-Ray / Blood Tests)  **Y / N** Which?... | | |
| **Only answer these questions if your referral is for a low back problem** OR **pain in your legs coming from your back**, please answer carefully as they relate to important nerves that come from your back and **may require your immediate attention.**  Since your low back pain **started** or **worsened**, please indicate if you have had any changes regarding the following: | | |
| **Have you had any loss of sensation or altered sensation in your vaginal / genital area or back passage?** *(i.e. noticed any changes in sensation when you wipe yourself after going to the toilet OR change in sensation with sexual intercourse)* | | ☐ Yes ☐ No  *Details (how long etc):* |
| **Have you had any change in your bladder or bowel function?** *(i.e. incontinence or loss of control / increased frequency or being unable to go to the toilet)* | | ☐ Yes ☐ No  *Details (how long etc):* |
| **Have you had any changes in sexual function?** *(i.e. are you still able to achieve and maintain an erection, do you have normal sensation during sexual intercourse)* | | ☐ Yes ☐ No  *Details (how long etc):* |
| **\*\*\*If YES to any of the above you must call 111 or attend A&E IMMEDIATELY\*\*\*** | | |

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| --- | --- |
| **Relevant Medical History:** *Please select Yes or No for* ***ALL*** *of the following:* | |
| |  |  |  | | --- | --- | --- | | **Condition** | **Yes** | **No** | | Heart Problems |  |  | | Lung Problems |  |  | | Diabetes |  |  | | Epilepsy |  |  | | Major Illness / Surgery |  |  | | Rheumatoid Arthritis / Family History |  |  | | TB |  |  | | Fractures |  |  | | Osteoporosis |  |  | | Cancer (Past / Current) |  |  | | Disturbed sleep due to pain |  |  | | High Blood Pressure |  |  | | Do you have any allergies |  |  |   *If you have answered* ***YES*** *to* ***ANY*** *of the medical conditions above OR have a condition not listed,* ***please give further details:*** | |  |  |  | | --- | --- | --- | | **Condition** | **Yes** | **No** | | Nausea Vomiting |  |  | | Headaches |  |  | | Double Vision |  |  | | Unexplained Weight Loss |  |  | | Fainting / Blackouts / Drop Attacks |  |  | | Problems with Speech |  |  | | Problems with Swallowing |  |  | | Smoker (Past / Present) |  |  | | Alcohol consumption > 14 Units per week |  |  | | Deteriorating mobility in last 12 months |  |  | | Any falls in last 12 months |  |  | | Have you ever taken steroids |  |  | | Have you taken blood thinning medication |  |  |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Please list your current medications:** | |
| In order to get the most out of your appointment, it is helpful for us to understand what matters most to you (e.g getting a diagnosis, keeping up with your grandchildren or continuing to work). Please let us know what matters most to you at the moment so we can do our best to support you. | |
| Have you or your immediate family, served in British Armed Forces? Yes / No | |

Please tick if you are happy to be contacted by one of our physiotherapists to discuss ways in which can improve our service ☐