**Self-Referral Form for Physiotherapy - Brighton and Hove**

**Please consult your GP URGENTLY** or call free NHS 111 (dial 111) if you have recently or suddenly developed:  
*- A change in your bladder function or bowel control.  
- Altered sensation around your genitals or back passage.  
- Loss of sexual function.  
- Pins and needles or numbness in both legs.*

**Please complete all parts of this form in black ink** and hand in or send to:  
*Royal Sussex County Hospital, Outpatient Booking Centre, Lower Ground Floor, Elliot House, Eastern Road, BN2 5BE*You can also complete this referral online at: sussexmskpartnershipcentral.co.uk/physiotherapy

**Important Notice for all Patients**

**Please consult your GP first** if you have any of the following:  
*- Have a history of cancer within the last 5 years.  
- Have any unexplained weight loss.  
- Are feeling generally unwell / feverish.  
- Have recently become unsteady on your feet.*

**Your Personal Details**

**Please do NOT complete this form** and instead consult your GP for advice if:  
*You are under 16* **OR** *you are seeking Physiotherapy treatment for neurology or respiratory disorders.*

**Address** .............................................................................

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**Postcode** ……………………………………………………………………….

**Title**  ......................... **Gender** …………………

**First Name .**…………………………………………………………………

**Surname .**………………………………………………………………… **D.o.B** …………….../…..…………./…..………………………...  
  
 **NHS No.** ………………………………………………………………….  
 *(available from Medical Letters or Prescriptions)*

**Email Address**

……………………………………………………………………………………….

Are you happy to receive correspondence via email?  
Yes  No    
Are you happy for a message to be left on your phone?  
Yes  No

**Telephone** *(please tick preferred number)* Home ………………………………………………………………....

Mobile …………………………………………………………………..

Work …………………………………………………………….……

**GP Name** …………………………………………………………………. Did your GP advise you to complete this form? Yes  No

**GP Practice (continued on next page)**

Albion Street Surgery  Allied Medical Practice  Arch Healthcare  Ardingly Court Surgery

Beaconsfield Medical  Benfield Valley Hub  Brighton Health & Wellbeing  Brighton Station Health Ctr

Broadway Surgery  Carden Surgery  Hove Medical Centre  Hove Park Villas Surgery

Links Road Surgery  Matlock Road Surgery  Mile Oak Medical Centre  Montpelier Surgery

North Laine Medical  Pavilion Surgery  Park Crescent Health Centre  Portslade Health Centre

Preston Park Surgery  Regency Surgery  Saltdean & Rottingdean Medical Practice

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**GP Practice (continued)**

Ship Street Surgery  St Luke’s Surgery  St Peter’s Medical Centre  Stanford Medical Centre

The Avenue Surgery  The Haven Practice  The Charter Medical Centre  The Seven Dials Medical

Trinity Medical Centre  Warmdene Surgery  Wellsbourne Healthcare CIC  Wish Park Surgery

Woodingdean Surgery  University of Sussex Health Centre  
 Other (please specify) …………………………………………………………………………………………………………………..

Is your pain constant (present all the time with no relief)? Yes  No

If yes have your symptoms come on since the start of the pregnancy?  
Yes  No

Is your pain getting:

Better Staying the same

Worse Other

If you selected “Other”, please specify …………………………………………………………………………………………………

Have you had a similar problem in the past? Yes  No   
If yes, how long ago and how was it managed? Did you have any treatment or see a specialist? Please give us the details.

How long have you had your current symptoms?

Less than 2 weeks 2-6 weeks 6-12 weeks

3-6 months More than 6 months Other

If you selected “Other”, please specify …………………………………………………………………………………………………

Please describe your current symptoms, including how they started, any pain, weakness or altered sensation.

Please tick the box that indicates the area of your problem *(please tick up to 3 boxes)*

Neck Knee Foot/Ankle

Shoulder Hip Hand/Wrist

Elbow Back Other

If you selected “Other”, please specify …………………………………………………………………………………………………

Are you pregnant?  
Yes  No

Is your pain or problem related to a recent injury or fall? Yes  No

Is this problem related to current or previous active service in the armed forces? Yes  No

**About Your Current Problem**

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On a scale of 1-10 (with 1 being no pain and 10 being the worst pain you have experienced), how would you score your symptoms? *Please tick as appropriate.*

Today 1 2 3 4 5 6 7 8 9 10

At best 1 2 3 4 5 6 7 8 9 10

At worse 1 2 3 4 5 6 7 8 9 10

Please list any medication you are taking for this current problem (e.g. painkiller/anti-inflammatories).   
Plus any other medications for other medical issues not related to this problem.

**Thank you for completing this form.  
If you have not heard from us within 4 weeks please contact us on 01273 665003.**

**Additional Information**

Do you have any special requirements?

Sight impairment Hearing impairment

Speech impairment Behavioural and Emotional

Learning Disability

Interpreter (please specify language) ………………………………………………………………………………………………….

Other (please specify) ……………………………………………………….………………………………………………………………..

Have you ever been diagnosed with cancer? Yes  No

If so, please give details? ………………………………………………………………………………………………………………………..

Please tell us about any other medical conditions or ongoing medical issues you are receiving treatment for.

Have your recent symptoms affected your sleep pattern? Yes  No

If so, how often is this occurring? …………………………………………………………………………………………………………..

Are you off work because of this problem? Yes  No

If so, how long for? ………………………………………………………………………………………………………………………………..

Are you unable to care for someone because of this problem? Yes  No

If so, please give details? ………………………………………………………………………………………………………………………..

Are your day to day activities affected by your pain?

Not at all Mildly

Moderately Severely