**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** .............................................................................

 ………………………………………………………………………..

 ……………………………………………………………………….

 ……………………………………………………………………….

**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

**Page 1 of 3**

**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**

**Page 2 of 3**

­­

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