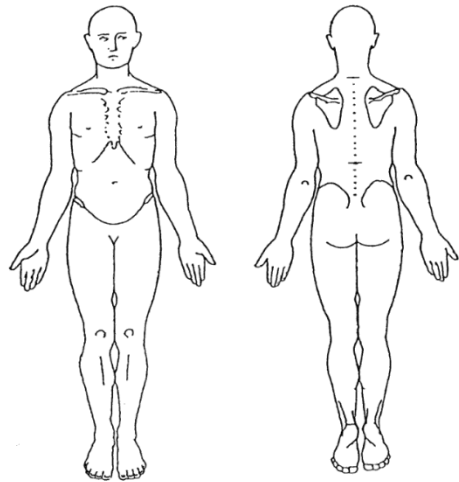


Physiotherapy Self-Referral Form

Please Note – This form should be used to access Physiotherapy for **one** musculoskeletal complaint/condition. If you have multiple joint or muscle pains please contact your GP for advice.

Title: Surname: First names :	NHS NUMBER: Date Of Birth: (If you are under 16 years of age a direct referral from your GP is required)
Address:	Daytime Contact telephone number: Email Address:
Postcode :	GP Name: GP Address: Billingshurst Surgery, Roman Way, Billingshurst RH14 9QZ
Are you off work because of this problem? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Work Are you unable to sleep because of this problem? <input type="radio"/> No <input type="radio"/> Yes ...if yes, how many nights per week:	Hobbies/ Activities (are you able to carry out your normal duties? If No, please explain what these are and why you are unable to carry them out at present)
What is the Problem?	
Which Body Part or Where is your problem? Please write below or indicate on the picture (NB We can only address one complaint on this form)	
How did this start?	
When did this Start (what date)?	Since your problem has started has it: <input type="radio"/> Got Better <input type="radio"/> Stayed the Same <input type="radio"/> Got Worse



Name	D.O.B
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Have you had any treatment for this condition recently or for a previous episode

- Yes : Please give details:
- No

Did it help?

- Yes
- No

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		
Family history of Rheumatoid Arthritis		
Pins and needles / numbness		
Fractures		
Osteoporosis		
Cancer (past or current)		
Bladder or bowel problems		
Nausea / vomiting		
Headaches		
Double vision		
Unexplained weight change		
Fainting / blackouts/ drop attacks		
Problems with speech		
Problems with swallowing		

If you have answered yes to any of the above or have a condition not listed? Please give details:

Current medication

Medication	Yes	No
Have you ever taken steroids?		
Have you ever taken anticoagulants (blood thinners e.g. aspirin / warfarin)		

Please list your current medication:

Do you have any allergies:

- No
- Yes...if yes please give details:

Any Investigations for this current problem?	No	Yes	If Yes please give details (e.g result / date)
X-ray			
MRI /CT scan			
Ultrasound scan			
Blood tests			
Other tests			

Name :

DOB:

Please name up to five of your daily activities with which you have difficulty due to your condition and score them in respect to how well or otherwise you can carry them out. 10 able to do without any problem 0 unable to do them at all. e.g. going up stairs 6/10 (moderate difficulty).

Daily Activity	Score										
	Unable To Do										Without any Problem
Eg Going Up Stairs	0	1	2	3	4	5	6	7	8	9	10
1:											
2:											
3:											
4:											
5:											

Please send this completed form to:

Email:

SC-TR.Coastal-MSK-Physios@nhs.net

Postal Return Address:

Physiotherapy Department
Bognor Regis War Memorial Hospital
Shripney Road
Bognor Regis
PO22 9PP
Fax 01243 623547

Unless you are a patient from Witterings Medical Centre or Pulborough Medical Group then please send to the appropriate address indicated to the right

When using this email address, Sussex Community NHS Trust cannot guarantee the security of this email, or be responsible for the security of any emails once sent or those in the sender's own email inbox. Once received, any personal details contained in this email will remain confidential in accordance with Sussex Community NHS Trust policies and procedures and relevant government legislation.

Return address for Pulborough and Billingshurst Medical Centre Patients

Physiotherapy department
Pulborough Medical Group
Spiro Close
Pulborough
West Sussex
RH20 1FG

Return Address for Witterings Medical Centre Patients

Witterings Medical Centre
Physiotherapy Department
Cakeham Road
East Witterings
West Sussex
PO20 8BH