**PHYSIOTHERAPY SELF-REFERRAL FORM** Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_

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| ***Important Notice*** *: This self-referral option is not available to patients under 16 years of age*  *Please complete* ***both sides*** *of this form & return to* ***Physio Outpatient Admin, St Clements Rd, Keynsham, Bristol BS31 1AF***  *Or email to:* [**vcl.bathnesphysio-outpts@nhs.net**](mailto:vcl.bathnesphysio-outpts@nhs.net)  *If you live in BA1 area hand in directly to the physiotherapy department or post direct to:* **Adult Therapies Department F1, Royal United Hospital Bath NHS FT, Combe Park, Bath, BA1 3NG** or email to  [**ruh-tr.therapiesoutpatientadmin@nhs.net**](mailto:ruh-tr.therapiesoutpatientadmin@nhs.net) |

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| **Patient Details** | | | | |
| Name : |  | | | |
| Address and Postcode: |  | | | |
| Date of Birth : |  | | | |
| Telephone : | Home :  Mobile : | |  |  |
| Is an Interpreter required? | Yes / No | | If “yes”, what language? |  |
| GP Name and Address: |  | | | |
| Have you consulted your GP about this problem? | Yes / No | If “yes”, what was recommended? | | |

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| **Your injury or problem** | | | |
| Please give a description of your problem (such as area of pain / how it started) : | | | |
| ***Please note :*** *If you have had any of the following please see your GP before referring yourself to physiotherapy* | | | |
| Fever or night sweats |  | History of cancer |  |
| Night pain |  | Unexpected bladder or bowel problems |  |
| Unsteady on feet |  | Unexpected weight loss |  |
| Hot or swollen joint(s) |  | | |

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| **How long have you had this problem?** | | | |
| Less than two weeks |  | More than two weeks |  |
| More than a month |  | More than a year |  |

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| **Is the problem :** | | | | | |
| New problem |  | Flare up of old problem |  | Ongoing long-term problem |  |
| **Is the problem:** | | | | | |
| Getting better |  | Getting worse |  | Staying the same |  |

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| **Have you had any investigations for this problem?** | | | | | |
| Blood test |  | MRI |  | Ultrasound |  |
| X-Ray |  |  | | | |

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| **Have you had any previous treatment for this problem?** | |
| If so, when was this treatment? |  |

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| **Medication & Medical history – please list any regular medication, medical conditions or previous surgery you have had.** |
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Body Chart – Can you mark on the body where you are getting the pain / problem, including any symptoms such as tingling :



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| **Due to your current problem, are you unable to do any of the following (give as much detail as possible)** | | | |
| Care of a dependent |  | Participate in sports or activities |  |
| Work |  | Other |  |

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| **Your Perception** |
| What do you think is happening or happened to cause your problem? |
| What specific problem(s) or difficulties would you like the physiotherapist to help you with? |
| Early advice – if you feel your condition can be managed with some advice and not an appointment and you would like a physiotherapist to call you and discuss the most appropriate way to manage your problem, please tick here : |