

Self-Referral Form for Physiotherapy at Horsham

You must be aged 17 years to be seen by the SMSKP Physiotherapy Service. If you are under 17, please contact your GP for advice.

Please complete all parts of this form and hand in or send to:

Physiotherapy Department, Horsham Hospital, Hurst Road, Horsham, West Sussex, RH12 2DR

You can also complete this referral online. Please visit: <http://sussexmskpartnershipcentral.co.uk/physiotherapy/>

Important Notice

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
- * Loss of bowel control
- * Altered sensation around genitals or back passage
- * Loss of sexual function
- * Pins and needles or numbness in **both** legs

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/fever
- * Have recently become unsteady on your feet

Personal Details

Name			Surname				
Address							
Postcode			Date of Birth				
Telephone (please tick preferred number)	Home	<input type="checkbox"/>	Are you happy for a message to be left?	YES	NO		
	Mobile	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
	Work	<input type="checkbox"/>	Are you happy to receive correspondence via e-mail?	YES	NO		
e-mail address			<input type="checkbox"/>	<input type="checkbox"/>			
NHS Number (if known)							
GP Practice	<input type="checkbox"/>	Courtyard Surgery	<input type="checkbox"/>	Holbrook Surgery			
<input type="checkbox"/>	Orchard Surgery	<input type="checkbox"/>	Park Surgery	<input type="checkbox"/>	Riverside Surgery		
<input type="checkbox"/>	Rudgwick Medical Centre	<input type="checkbox"/>	The Village Surgery Southwater	<input type="checkbox"/>	Other		
If you have ticked 'Other' please give further information:							
GP Name			Did your GP advise you to complete this form?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Do you have any special requirements (e.g. do you require an interpreter)?				YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
If you have ticked 'Yes', please give details of what is required							

About your current problem

Is your pain or problem related to a recent injury or fall?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this problem related to a current or previous active service in the armed forces?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you pregnant?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>Where is your problem?</p> <p><input type="checkbox"/> Neck <input type="checkbox"/> Knee <input type="checkbox"/> Foot/Ankle</p> <p><input type="checkbox"/> Shoulder <input type="checkbox"/> Hip <input type="checkbox"/> Hand/Wrist</p> <p><input type="checkbox"/> Elbow <input type="checkbox"/> Back <input type="checkbox"/> Other</p> <p>If you selected "Other", please specify</p>	<p>How long have you had your current symptoms?</p> <p><input type="checkbox"/> Less than 2 weeks <input type="checkbox"/> 3-6 months</p> <p><input type="checkbox"/> 2-6 weeks <input type="checkbox"/> More than 6 months</p> <p><input type="checkbox"/> 6-12 weeks <input type="checkbox"/> Other</p> <p>If you selected "Other", please specify</p>		
Please describe your current symptoms, including how they started, any pain, weakness or altered sensation			
Have you had these or similar problems in the past? If yes how long ago and how was your condition managed at the time?			
Is your pain getting: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Staying the same <input type="checkbox"/> Other (please specify below)			
Is your pain constant (present all the time with no relief)?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>On a scale of 0-10 (with 0 being no pain and 10 being the worst pain you have experienced), how would you score your symptoms? Please circle as appropriate</p> <p>Today 1 2 3 4 5 6 7 8 9 10</p> <p>At best 1 2 3 4 5 6 7 8 9 10</p> <p>At worse 1 2 3 4 5 6 7 8 9 10</p>		<p>Have your recent symptoms affected your sleep pattern? And if so, how often is this occurring?</p>	
<p>Are your day to day activities affected by your pain?</p> <p><input type="checkbox"/> Not at all <input type="checkbox"/> Mildly <input type="checkbox"/> Moderately <input type="checkbox"/> Severely</p>		<p>Are you off work because of this problem? If so, how long for?</p>	
<p>Please list any medication you are taking for this current problem (e.g. painkillers/ anti-inflammatories)</p>		<p>Are you unable to care for someone because of this problem? If yes, please give detail</p>	
Thank you for completing this form			