Sussex MSK Partnership Central

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 ☐	Are you happy for a message to be left?	YES ☐ NO ☐
	Mobile ☐		
	Work ☐	Are you happy to receive correspondence via e-mail?	YES ☐ NO ☐
e-mail address			
NHS Number (if known)			

GP Practice

☐ Courtyard Surgery	☐ Holbrook Surgery	☐ Orchard Surgery
☐ Park Surgery	☐ Riverside Surgery	☐ Rudgwick Medical Centre
☐ The Village Surgery Southwater	☐ Other	

If you have ticked 'Other' please give further information:

GP Name		Did your GP advise you to complete this form?	YES ☐ NO ☐
Do you have any special requirements (e.g. do you require an interpreter)?			YES ☐ NO ☐

If you have ticked 'Yes', please give details of what is required

Please turn over to page two ⇨

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NHS

About your current problem

Is your pain or problem related to a recent injury or fall?	Yes ☐	No ☐
Is this problem related to a current or previous active service in the armed forces?	Yes ☐	No ☐
Are you pregnant?	Yes ☐	No ☐

Where is your problem?

☐ Neck ☐ Knee ☐ Foot/Ankle

☐ Shoulder ☐ Hip ☐ Hand/Wrist

☐ Elbow ☐ Back ☐ Other

If you selected "Other", please specify

How long have you had your current symptoms?

☐ Less than 2 weeks ☐ 3-6 months

☐ 2-6 weeks ☐ More than 6 months

☐ 6-12 weeks ☐ Other

If you selected "Other", please specify

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: ☐ Better ☐ Worse ☐ Staying the same ☐ Other (please specify below)

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

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

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

Have your recent symptoms affected your sleep pattern? And if so, how often is this occurring?

Are your day to day activities affected by your pain?

☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely

Are you off work because of this problem? If so, how long for?

Please list any medication you are taking for this current problem (e.g. painkillers/ anti-inflammatories)

Are you unable to care for someone because of this problem? If yes, please give detail

Thank you for completing this form