**PAR – Referral Form**

**Context Page**This survey has been designed to ensure we give you the most appropriate treatment and support. You must complete
all questions marked with \* to provide the information we need to ensure you receive the most suitable support.

**Important Notice for all Patients**

**Please do NOT complete this form** and instead consult your GP for advice if:
*You are aged 16 years or under* **OR** *you are seeking Physiotherapy treatment for neurology or respiratory disorders.*

**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 consult your GP before completing this form**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.*

**To be Completed by the GP**

**Patient’s Email Address**

……………………………………………………………………………………….

**Patient’s NHS Number**……………………………………………………………….............................

Has the patient given consent for SMSKP to access medical records held by the GP practice?\* Yes ☐ No ☐
*i.e. past medical history and drug history.*

**To be Completed by the Patient**

**Please tell us in which area your GP is located\***

☐Brighton and Hove ☐East Grinstead ☐Crawley

☐Horsham ☐Mid-Sussex (Burgess Hill and Haywards Heath)

**Brighton GP Practices** please select your GP Practice\*

☐ 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
☐ 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 ☐ Wish Park Surgery ☐ Woodingdean Surgery

☐ University of Sussex Health Centre
☐ Other (please specify) …………………………………………………………………………………………………………………………………………………………..

**East Grinstead GP Practices** please select your GP Practice\*

☐ Ship Street Surgery ☐ Judges Close Surgery ☐ Moatfield Surgery ☐ Crawley Down Health Centre

☐ Other (please specify) …………………………………………………………………………………………………………………..

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**Crawley GP Practices** please select your GP Practice\*

☐ Bewbush Medical Centre ☐ Gossops Green Medical Centre ☐ Pound Hill Surgery

☐ Bridge Medical Centre ☐ Ifield Medical Practice ☐ Saxonbrook Medical Centre

☐ Coachmans Medical Practice ☐ Langley Corner Surgery ☐ Southgate Medical Group

☐ Furnace Green Surgery ☐ Leacroft Medical Practice ☐ Woodlands & Clerklands Partnership

☐ Other (Please specify) …………………………………………………………………………

 **Title**  ......................... **Gender** …………………

 **First Name .**…………………………………………………………………

 **Surname .**………………………………………………………………… **D.o.B** …………….../…..…………./…..………………………...

 **Phone No.** ………………………………………………………………….

How can we contact you?\*

Are you happy to receive correspondence via email? Yes ☐ No ☐
Are you happy for a voicemail to left on the above number? Yes ☐ No ☐

Any further comments ……………………………………………………………………………………………….…………………………… ………………….

Is this problem related to current or previous service in the armed forces?\* Yes ☐ No ☐
*All veterans are entitled to priority access to NHS care (including hospital, primary, or community care) for conditions associated to their time within the armed forces (service-related). This is subject to clinical need and does not entitle you to jump the queue ahead of someone with a higher clinical need.*

**Your Personal Details**

**Address** .............................................................................

 ………………………………………………………………………..

**City/Town** ……………………………………………………………………….

**County** ……………………………………………………………………….

**Postcode** ……………………………………………………………………….

**Mid-Sussex GP Practices** please select your GP Practice\*

☐ The Brow Medical Centre ☐ Dolphins Practice ☐ Lindfield Medical Centre

☐ The Meadows Surgery ☐ Mid-Sussex Health Ditchling/Hassocks☐ Newton Surgery

☐ Northlands Wood Practice ☐ Ouse Valley Practice ☐ Park View Health Partnership

☐ Silverdale Surgery ☐ The Surgery Cowfold ☐ Cuckfield & The Vale Surgery

☐ Other (Please specify) …………………………………………………………………………

**Horsham GP Practices** please select your GP Practice\*

☐ Holbrook Surgery ☐ Orchard Surgery ☐ Park Surgery

☐ Riverside Surgery ☐ Rudgwick Medical Centre ☐ The Village Surgery Southwater

☐ Other (Please specify) …………………………………………………………………………

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

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 …………………………………………………………………………………………………

Is there anything that worries you about your condition or your symptoms?

Please tell us about the problem for which you are seeking treatment.\*
*Please describe when and how it started (for example a fall, any pain, swelling, or weakness) and if you have any altered sensations (for example numbness or pins and needles).*

Please tick the box which best describes the area of your problem, so we can direct your referral to the right specialist clinician.\*
*You will have the opportunity to discuss all aspects of your condition at your appointment.*

☐Spine (including neck) ☐Shoulder/Elbow ☐Hand/Wrist

☐Hip/Knee ☐Foot/Ankle ☐Widespread Pain

Do you have any special requirements?

☐Sight impairment ☐Hearing impairment

☐Speech impairment ☐Behavioural and Emotional

☐Learning Disability

☐Other (please specify) ……………………………………………………….…………………………………………………………………………………..…

Please give details of how we can help you

………………………………………………………………………………………………………………………………………………………………………………………..

☐Do you need an Interpreter (please specify language) ……………………………………………………………………………………………..

**About Your Current Problem**

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☐

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Please list any medication you are taking for this current problem (e.g. painkiller/anti-inflammatories).
Plus any other medications for other for other medical issues not related to this problem.

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 you had a similar problem in the past?\* Yes ☐ No ☐
*If yes, how long ago and how was it managed at the time?*

Have you previously had any treatment for this problem?\* Yes ☐ No ☐
*If yes, what kind of specialist did you see and when? (e.g. physiotherapist, consultant, osteopath)*