South Eastern Health and Social Care Trust

Self - Referral to Musculoskeletal Physiotherapy

Self-referral is available for ***adults over 16*** who need support and advice to manage symptoms related to muscle strains/joint sprains/back and neck pain. This referral option is *not* available if you are under the care of a consultant for this problem, or if you have neurological/respiratory/continence conditions. If you have Pregnancy related pain, please ask your GP/Midwife to refer you to the Pelvic Health/ Women's Health Physiotherapy Service who do not currently accept self-referrals.

First Name:*

Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Last Name:*

Date of Birth:*

Male ☐ Female ☐

Health and Care (H&C) Number:________________ (*If known*)

Your Address:*

Postcode:

*Contact details: Please enter **telephone numbers** that you are happy to be contacted at if more information is required. Please tick box/s* if you are happy for us to leave a message at that number. If we ring you, it may display **unknown number** on your phone please be aware of this.

Home: ______________________ ☐

Work: ______________________ ☐

Mobile:______________________ ☐

Email address ____________________

Your GP's name and practice address:*

Did your GP suggest self-referral to Physiotherapy*

Yes ☐ No ☐

Do you require an interpreter?* Yes ☐ No ☐

If yes, which language?_________________________

Do you require adjustment for reasons related to a disability?*

Yes ☐ No ☐ If yes, please give details:

____

Where is your main problem?

(Please tick one box) *

Back ☐	Neck ☐	Shoulder ☐
Arm ☐	Elbow ☐	Wrist ☐
Hand ☐	Chest ☐	Hip ☐
Knee ☐	Leg ☐	Foot ☐

How long have you had this problem?

(Please tick)*

0-6 Weeks ☐ 7-12 Weeks ☐

>13 weeks ☐ >1 year ☐

Have you seen your GP or anyone else in your GP practice about this problem?

Yes ☐ No ☐

Is the problem?*

New ☐

Are your symptoms getting worse?

Yes ☐ No ☐

If yes in what way?

____

Are you able to carry out your normal activities, work, care for a dependant, sport at present?*

Yes ☐ No ☐

If No what are you having difficulty with?

____

Do you know what caused your problem? *

Yes ☐ No ☐

If yes please give details:

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Do you have any other medical condition or information that you think may be relevant e.g. Cancer, previous fractures, Diabetes, Osteoporosis?

____

____

Sometimes we miss what is most important to you, what is concerning you most?*

____

____

Have you lost weight in the **past 6 months** for reasons you cannot explain? * Yes ☐ No ☐

If yes how much?______________________________________

Have you developed Numbness / Tingling / Pins and Needles since the start of your problem?
Yes ☐ No ☐ **If yes where?** ____

Since the onset of your problem do you have any of the following symptoms? *

A **new** episode or a **sudden** change to your ability to control or to pass urine? Yes ☐ No ☐

A **new** loss of sensation to your inner thighs, genitals or back passage area? Yes ☐ No ☐

A **new** difficulty with Bowel function resulting in a loss of bowel control (soiling yourself) Yes ☐ No ☐

If you answered **YES** to any of the questions **above** and you **HAVE NOT** seen a doctor for this symptom, it is essential that you arrange for **URGENT** advice from your **GP** or attend your local **Emergency Department**

DO NOT SEND IN THIS FORM UNTIL YOU HAVE SOUGHT FURTHER ADVICE

Please tick where you wish to attend for assessment

Ards Community Hospital ☐ Bangor Community Hospital ☐ Downe Hospital ☐

Lagan Valley Hospital ☐ Lisburn Health Centre ☐ Stewartstown Road Clinic ☐ Saintfield ☐

I agree that the information that I have provided in this form is accurate*

Signature: ____

Please ensure all fields marked with* are completed or we will be unable to process the referral.

While you are waiting if you are concerned that your condition is worsening please seek medical advice.

On completion please return to: Central Booking Office, 1st Floor , Main Building, Downshire Hospital, Ardglass Road, Downpatrick, Co. Down, BT30 6RL

Or email it to: CBO.Physiotherapy@setrust.hscni.net