Date:……..

Western Sussex Hospitals NHS
NHS Foundation Trust

# Physiotherapy SELF-REFERRAL:

This service is for people who are over 16 with musculoskeletal problems, such as muscle and joint pain, sports injuries, back or neck pain, sprains and strains.

**If you are under 16**: please contact your GP and they can refer you to the paediatric physiotherapy team as appropriate.

If you do not wish to self-refer **OR** have difficulty communicating over the telephone, you can still contact your GP for a referral.

**Our catchment area is any GP practice from Littlehampton to Southwick.**

**Bognor & Chichester GP Practices access physiotherapy through the Sussex Community NHS Foundation Trust. (www.sussexcommunity.nhs.uk)**

## How do you refer yourself to physiotherapy?

By filling in this form and sending it to us at the address printed by post, by email OR by dropping it in to your local physiotherapy department. ***Please complete the form in full*** as the more information we have regarding your problem, the better we are able to direct and help you with your problem. We may send form back to you if we require more information than provided to help us give you the best care.

**You can find an online version of this form to complete here:**
http://www.westernsussexhospitals.nhs.uk/services/physiotherapy/physiotherapy-self-referral/

## What happens once you have contacted us?

Once we have your referral, a physiotherapist will review the information provided and organise the most appropriate course of treatment for you. We may contact you on the telephone to discuss your problem in greater detail to help in identifying the best management options for your problem:

**This might be:**

- Advice on how to manage your problem
- Advice and a home exercise programme sent to you via email or by post.
- You may be given an appointment for face-to-face treatment in the physiotherapy Department
- Advice to see your GP if we think the problem is not suitable for physiotherapy

The aim of this service is to allow people to access physiotherapy in a more convenient way, so that they can get their treatment started at the right time, aiding a quicker recovery.



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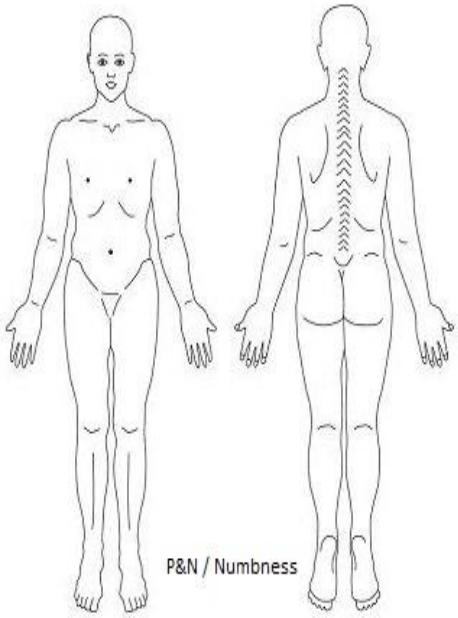
| | | | |
|---|---|---|---|
| **Title:**<br>**First Names:**<br>**Surname:** | | **Date of Birth:**<br>(If you are under 16 years of age a direct referral from your GP is required) | |
| **Address:**<br><br>**Post Code:** | | **Daytime Telephone:**<br>**Work Telephone:**<br>**Mobile Telephone:**<br>**Email Address:** | |
| **Are you pregnant?** Yes ☐ No ☐<br>**How many weeks?** _____ | | **GP Name:**<br>**GP Practice:** | |

| | | | | |
|---|---|---|---|---|
| **Are you happy for us to leave a voice message?** | Yes ☐ No ☐ | | | |
| **Preferred time of call?** | **AM early** | **AM late** | **PM early** | **PM late** |

**What is the Main Problem?**

Have you spoken to your Doctor / GP about this problem? ☐Yes ☐No

**Which body part or where is your problem?**
*(please write below or indicate on the picture)*




**Do you have any pins and needles / tingling sensations or numbness?**

☐ Yes … *if so please tell us where*:

☐ No

**When did the problem start?**

**How did the problem start?**

**Have you had any treatment for this condition recently or for a previous episode?**

☐ Yes ☐ No *Please give details:*

**Did it help?** ☐ Yes ☐ No

**Have you had any recent investigations? (**i.e. X-Ray / Blood Tests)

☐ Yes ☐ No Please give details:



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**Only answer these questions if your referral is for a <u>low back problem</u>** OR **<u>pain in your legs coming from your back</u>**, please answer carefully as they relate to important nerves that come from your back and **<u>may require your immediate attention</u>.**

Since your low back pain **started** or if it has **worsened**, please indicate if you have had any <u>changes</u> regarding the following:

| | |
|---|---|
| **Have you had any loss of sensation or altered sensation in your vaginal / genital area or back passage?** *(i.e. noticed any changes in sensation when you wipe yourself after going to the toilet OR change in sensation with sexual intercourse)* | ☐ Yes ☐ No<br>*Details (how long etc):* |
| **Have you had any change in your bladder or bowel function?** *(i.e. incontinence or loss of control / increased frequency or being unable to go to the toilet)* | ☐ Yes ☐ No<br>*Details (how long etc):* |
| **Have you had any changes in sexual function?** *(i.e. are you still able to achieve and maintain an erection, do you have normal sensation during sexual intercourse)* | ☐ Yes ☐ No<br>*Details (how long etc):* |

*****If YES to any of the above you must call 111 or attend A&E IMMEDIATELY*****

**Relevant Medical History:**
*Please select <u>Yes or No</u> for **ALL** of the following:*

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Heart Problems | | | High Blood Pressure | | |
| Lung Problems | | | Nausea Vomiting | | |
| Diabetes | | | Headaches | | |
| Epilepsy | | | Double Vision | | |
| Major Illness / Surgery | | | Unexplained Weight Loss | | |
| Rheumatoid Arthritis / Family History | | | Fainting / Blackouts / Drop Attacks | | |
| TB | | | Problems with Speech | | |
| Fractures | | | Problems with Swallowing | | |
| Osteoporosis | | | Smoker (Past / Present) | | |
| Cancer (Past / Current) | | | Alcohol consumption > 14 Units per week | | |

*If you have answered **YES** to **ANY** of the medical conditions above OR have a condition not listed, **please give further details:***

_____
_____
_____



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| **Please list your current medications:** | **Have you ever taken steroids?** ☐ Yes ☐ No<br><br>*(Details)*<br><br>**Have you ever taken blood thinning medication?** e.g. Aspirin ☐ Yes ☐ No<br><br>(Details)<br><br>**Do you have any Allergies?** ☐ Yes ☐ No<br><br>(Details) |
|---|---|

| | |
|---|---|
| Are you currently signed off work as a result of your problem? **If yes,** how many days off have you had to take? | *Details:* |
| Are you the main carer for friend / family member? **If yes,** is this role currently affected by your pain / symptoms? | *Details:* |
| Since your symptoms began, do you feel they are;<br>Improving ☐<br>Same ☐<br>Worsening ☐ | *Details: (time frame etc)* |

**Do you have any specific concerns / worries about your symptoms OR expectation on what you need to help your condition?**

_____

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**Return this form by post to your preference of:**

- Physio Dept, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH
- Physio Dept, Southlands Hospital, Old Shoreham Road, Shoreham-by-sea, BN43 6TQ
- Physio Dept, Littlehampton Health Centre, Fitzalan Road, Littlehampton, BN17 5HG

**OR** by email to:

- receptionwor.physio@wsht.nhs.uk (Worthing)
- receptionsou.physio@wsht.nhs.uk (Southlands)
- littlehampton.physio@wsht.nhs.uk (Littlehampton)

**NB. Email is not encrypted nor guaranteed to be completely secured.**

For Admin use only:

Urgent Appt ☐ Urgent PD ☐ Routine PD ☐ Routine W/L☐ GP ☐ N/A ☐



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