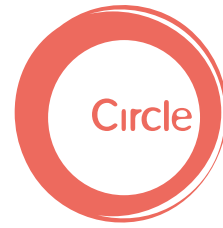


PLEASE NOTE: THIS IS NOT
A GP/CLINICIAN REFERRAL FORM



Integrated Care

Physio Line self-referral form

You can now self-refer to our Physio Line telephone service for muscle and joint problems if you meet the following criteria:

- You are aged 18 or over.
- You have had your condition for **less** than six months.
- Your GP is in the Greenwich CCG (if you are not sure please contact your GP surgery or visit their website).
- Your complaint is regarding a **single** (1) joint/area.

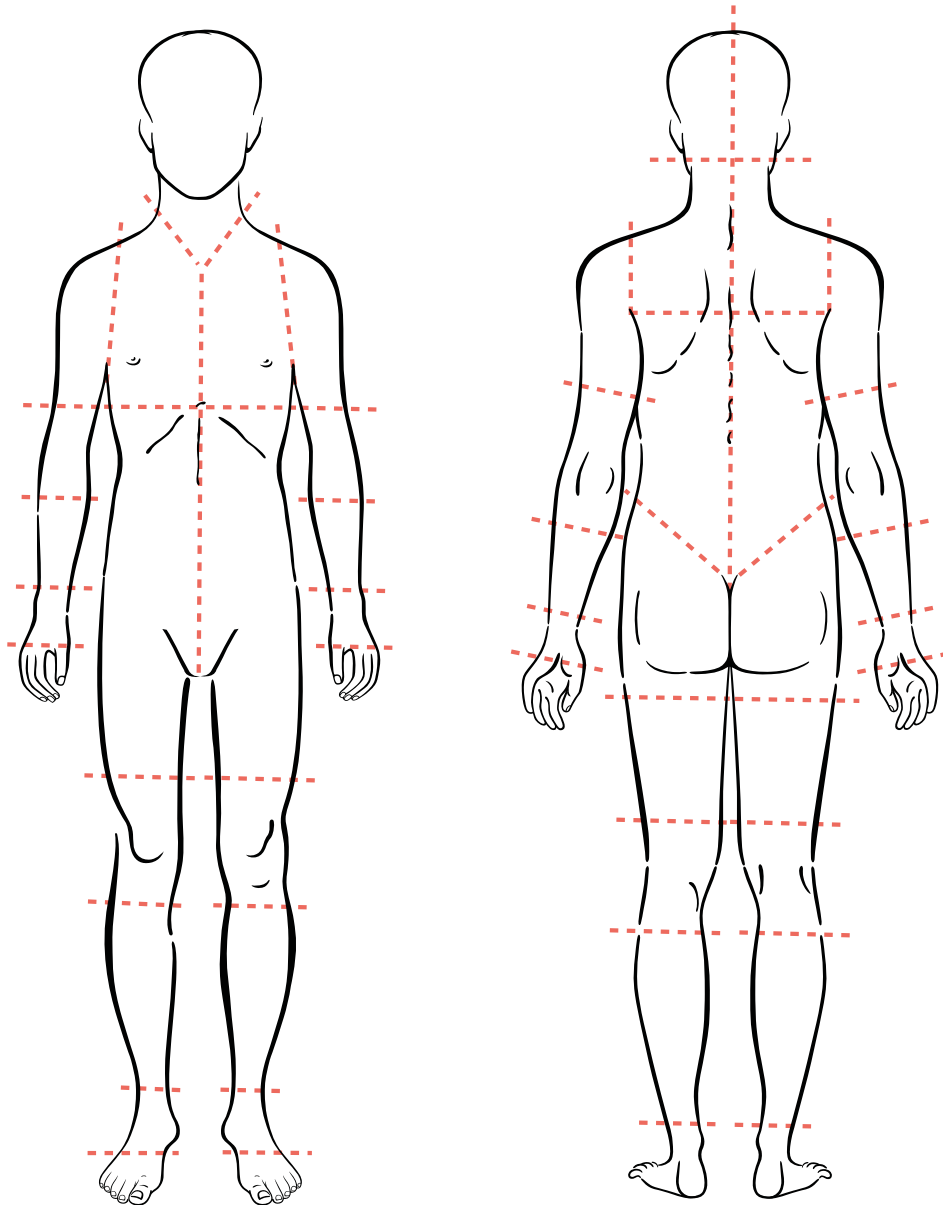
Please fully complete this form so we can gather as much information as possible regarding your condition.

In some cases, you may be required to see your GP for further assessment prior to being referred into the service. If you are completing this form by hand, please use block capitals.

* Denotes a mandatory field: referrals may be rejected if not fully completed.

Date	
*Name	
*Date of birth	*Gender
*Address	
*Postcode	
*Telephone	
*Email	
*GP name	
*GP surgery	
Height (m)	Weight (kg)

Click to shade in the area where you experience your symptoms on the body chart.



Please give a brief description of your problem and why you feel you need physiotherapy (please note this must be a single joint/area only).

Please complete the following questions regarding your current problem and how it affects you, on average, over the course of a week.

Impact on daily function e.g. work, caring duties, self-care	N/A <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Impact on sleep	N/A <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Severity of pain (where 0 = no pain and 10 = worst pain imaginable)	N/A <input type="checkbox"/>	1-4 <input type="checkbox"/>	5-7 <input type="checkbox"/>	8-10 <input type="checkbox"/>
Please indicate how much pain relief medication you are currently taking for this problem	None <input type="checkbox"/>	Some <input type="checkbox"/>	Maximum daily dose <input type="checkbox"/>	
Please write the names of any medications you are currently taking	<input type="text"/>			
How long have you had this problem?	Less than 6 weeks <input type="checkbox"/>	Between 6 weeks and 6 months <input type="checkbox"/>	Over 6 months <input type="checkbox"/>	
Did your problem start as a result of an injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are your symptoms worsening?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Do you have any other significant medical/health problems, e.g. cancer, heart problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	If yes, please give details: <input type="text"/>			
Have you had physiotherapy for this problem before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	If yes, how long ago? <input type="text"/>			

If you answer yes to any of the below, please see your GP first please.

<p>If you have back pain, have you had any change in sensation between your legs (the Saddle area), problems controlling your urine, bowels or change in sexual function?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>	<p>Not Applicable [Not back pain] <input type="checkbox"/></p>
<p>If you have back pain, have you had any difficulties controlling your urine?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>	
<p>If yes, is this a new problem, rather than an existing issue?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>	
<p>If yes, please provide further details</p>		<input type="text"/>	
<p>Have you suddenly lost weight without trying?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>	
<p>Have you had any symptoms such as numbness, tingling or muscle weakness?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>	
<p>Do you require an interpreter?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>	
<p>If yes, what language?</p>		<input type="text"/>	
<p>Where did you get a copy of this self-referral form?</p>	<p>GP <input type="checkbox"/></p>	<p>Physio clinic <input type="checkbox"/></p>	<p>Website <input type="checkbox"/></p>
<p>Other (please specify)</p>		<input type="text"/>	

Please return all forms to

Email:
msk.greenwich@nhs.net

Post:
Circle Integrated Care
Regent House
Wolseley Road
Kempston
Bedford MK42 7NY

NB: THIS IS A MAILING ADDRESS ONLY