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

Circle Integrated Care

PhysioLine self-referral form

You can now self-refer to our PhysioLine 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 (DD/MM/YYYY): (please note – this service is for over 18-year-olds only)

* Gender:

* Address:

* Postcode:

* Telephone:

* GP name:

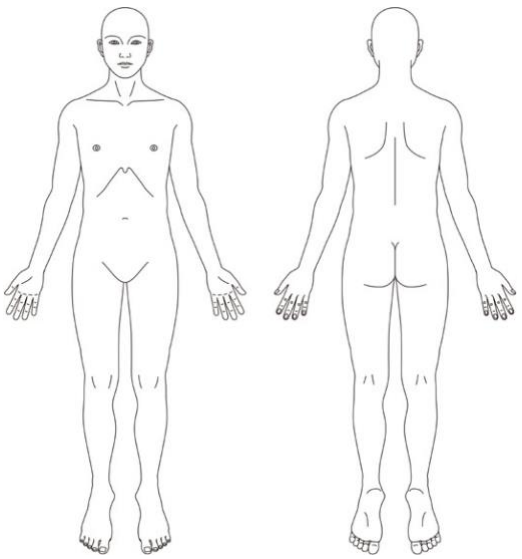
* GP surgery:

* Email:

Height (m)

Weight (kg)

Please mark the area where you experience your symptoms on the body chart below.



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 eg. work, caring duties, self-care N/A ☐ Mild ☐ Moderate ☐ Severe ☐

Impact on sleep N/A ☐ Mild ☐ Moderate ☐ Severe ☐

Severity of pain (where 0 = no pain and 10 = worst pain imaginable) N/A ☐ 1–4 ☐ 5–7 ☐ 8–10 ☐

Please indicate how much pain relief medication you are currently taking for this problem None ☐ Some ☐ Maximum daily dose ☐

Please write below the names of any medications you are currently taking:

How long have you had this problem? Less than six weeks ☐ Between six weeks and six months ☐ Over six months ☐

Did your problem start as a result of an injury? Yes ☐ No ☐

Are your symptoms worsening? Yes ☐ No ☐

Do you have any other significant medical/health problems, e.g. cancer, heart problems? Yes ☐ No ☐

If yes, please give details:

Have you had physiotherapy for this problem before? Yes ☐ No ☐

If yes, how long ago?

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

If you have back pain, have you had any difficulties controlling your urine? Yes ☐ No ☐

Have you suddenly lost weight without trying? Yes ☐ No ☐

Have you had any symptoms such as numbness, tingling or muscle weakness? Yes ☐ No ☐

Do you require an interpreter? Yes ☐ No ☐

If yes, what language?

Where did you get a copy of this self-referral form? GP ☐ Physiotherapy clinic ☐ Website ☐

Other (please specify)

Please return all forms to:

E: msk.greenwich@nhs.net | circlehealth.co.uk/msk

Post: Eltham Community Hospital, 30 Passey Place, London, SE9 5DQ (NB THIS IS A NON CLINICAL SITE)