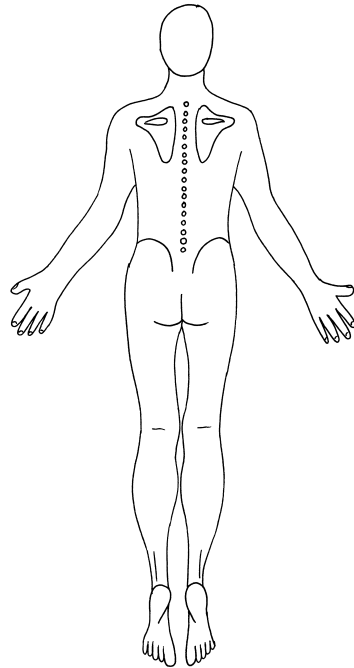
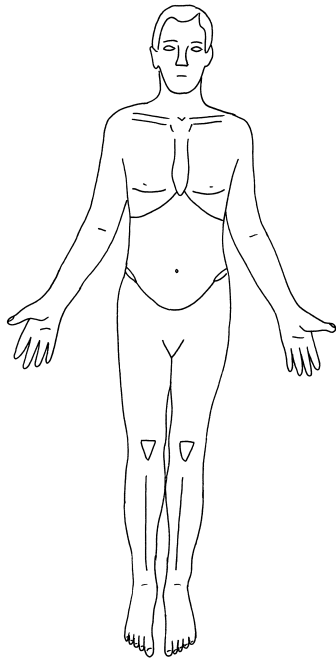


Medication	YES	NO
Steroids	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>

Please list ALL the medication you are taking

Indicate on the pictures where you get your symptoms, for example pain, pins and needles, numbness



Please make sure you have filled in all parts of the form

Signature _____
Date _____

If you have any problems completing this form, please ring the number below.
Please return this form to:

Physiotherapy Department
Montgomery County Infirmary
Llanfair Road, Newtown
SY16 2EH

Tel: 01686 617207

Physiotherapy Department
Victoria Memorial Hospital
Salop Road, Welshpool
SY21 7DU

Tel: 01938 558930

Physiotherapy Service Self Referral Form

This form should only be used for patients wishing to have physiotherapy for musculoskeletal problems (back/neck pain, joint pain, soft tissue injuries). If you are under the age of 16, you should discuss with your Health Practitioner first.

This form will be used to determine how your referral is processed. Please ensure you:

- Use a **BLACK** Pen
- Use **BLOCK CAPITALS**
- Complete **ALL** sections of the form

Incomplete forms will be returned to you which will cause a delay in the management of your problem. Once received, the form will be reviewed and placed on a waiting list.

Full Name	Office Use Only	
	Status	Date
Address	Received	
	Urgent/Routine	
	Partial Book sent	
	Date Contacted	
	Appt Given	
Post Code	Did not Phone/DC	
Date of Birth: / /	Your Contact Telephone Numbers	Can we leave a message?
GP Name _____	Home _____	Yes / No
Practice _____	Work _____	Yes / No
_____	Mobile _____	Yes / No

Please give a brief description of your symptoms, or why you wish to see a physiotherapist

How long have you had this problem? Days Weeks Months Years

How did it start? (*Just came on, injury, fall, long term problem etc*)

Are you in pain all the time or does it come and go?

Pain all the time
Comes and goes

How often do you have the pain? _____

What makes the pain WORSE?

What makes the pain BETTER?

Is it generally worse? *Tick answer that applies most*

In the morning In the afternoon In the evening At night No pattern

Have you had treatment / physiotherapy for this condition in the past? **Yes / No**
(if YES, please give details)

Have you had any X-rays or other tests? **Yes / No** *(if YES, please give details/ results)*

Have you had this problem before? **Yes / No** *(if YES, please give details)*

If this is a problem with your joints:

Does your joint? YES NO YES NO YES NO YES NO
Give Way Click Lock Swell

Are you off work or unable to care for a dependant because of this problem? **Yes / No**
(if yes, please give details)

Please indicate any activities you are unable to do because of this problem

What are your expectations from Physiotherapy?

SINCE THE ONSET OF THIS PROBLEM Do any of the following apply to you? If you have the symptoms please tick YES If you do not have the symptoms please tick NO

	YES	NO
Bladder Problems —a difficulty in passing water or feeling you cannot empty your bladder	<input type="checkbox"/>	<input type="checkbox"/>
Bowel problems —a loss of bowel control (soiling yourself)	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>

If you have ticked **YES** to any of these symptoms, and you **HAVE NOT** seen a doctor for this symptom, it is essential you arrange an **URGENT** appointment with your **GP** or call **NHS Direct** on (0845 46 47) or attend your local **A&E Department**

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

General Health	YES	NO	YES	NO	
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Fractures / Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
			Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Lung / Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered YES to any of the above or have any other medical problems, please provide further details here: