

## Self-Referral Form for Physiotherapy at Crawley

You must be aged 17 years to be seen by the SMSKP Physiotherapy Service. If you are under 17, please contact your GP for advice.

Please complete all parts of this form and hand in or send to:

Physiotherapy Department, Ground Floor, Crawley Hospital, West Green Drive, Crawley, West Sussex, RH11 7DH

You can also complete this referral online. Please visit: [sussexmskpartnershipcentral.co.uk/physiotherapy](http://sussexmskpartnershipcentral.co.uk/physiotherapy)

### Important Notice

**Please consult your GP URGENTLY or call free NHS 111 (Dial 111) if you have recently or suddenly developed:**

- \* A change in your bladder function
- \* Loss of bowel control
- \* Altered sensation around genitals or back passage
- \* Loss of sexual function
- \* Pins and needles or numbness in **both** legs

**Please consult your GP first if you have any of the following:**

- \* Have a history of cancer within the last 5 years
- \* Have any unexplained weight loss
- \* Are feeling generally unwell/fever
- \* Have recently become unsteady on your feet

### Personal Details

Name			Surname				
Address							
Postcode			Date of Birth				
Telephone (please tick preferred number)	Home	<input type="checkbox"/>	Are you happy for a message to be left?	YES	NO		
	Mobile	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
	Work	<input type="checkbox"/>	Are you happy to receive correspondence via e-mail?	YES	NO		
e-mail address			<input type="checkbox"/>	<input type="checkbox"/>			
NHS Number (if known)							
GP Practice	<input type="checkbox"/>	Coachmans Medical Practice	<input type="checkbox"/>	Bewbush Medical Centre	<input type="checkbox"/>	Bridge Medical Centre	
	<input type="checkbox"/>	Ifield Medical Practice	<input type="checkbox"/>	Furnace Green Surgery	<input type="checkbox"/>	Gossops Green Medical Centre	
	<input type="checkbox"/>	Pound Hill Surgery	<input type="checkbox"/>	Langley Medical Practice	<input type="checkbox"/>	Leacroft Medical Practice	
	<input type="checkbox"/>	Woodlands and Clerklands Partnership	<input type="checkbox"/>	Saxonbrook Medical Centre	<input type="checkbox"/>	Southgate Medical Group	
			<input type="checkbox"/>	Other (please specify)			
GP Name			Did your GP advise you to complete this form?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Do you have any special requirements (e.g. do you require an interpreter)?				YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
If you have ticked 'Yes', please give details of what is required							

## About your current problem

Is your pain or problem related to a recent injury or fall? Yes  No

Is this problem related to a current or previous active service in the armed forces? Yes  No

Are you pregnant? Yes  No  If yes have your symptoms come on since the start of the pregnancy? Yes  No

<p>Where is your problem?</p> <p><input type="checkbox"/> Neck      <input type="checkbox"/> Knee      <input type="checkbox"/> Foot/Ankle</p> <p><input type="checkbox"/> Shoulder      <input type="checkbox"/> Hip      <input type="checkbox"/> Hand/Wrist</p> <p><input type="checkbox"/> Elbow      <input type="checkbox"/> Back      <input type="checkbox"/> Other</p> <p>If you selected "Other", please specify</p>	<p>How long have you had your current symptoms?</p> <p><input type="checkbox"/> Less than 2 weeks      <input type="checkbox"/> 3-6 months</p> <p><input type="checkbox"/> 2-6 weeks      <input type="checkbox"/> More than 6 months</p> <p><input type="checkbox"/> 6-12 weeks      <input type="checkbox"/> Other</p> <p>If you selected "Other", please specify</p>
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Please describe your current symptoms, including how they started, any pain, weakness or altered sensation

Have you had these or similar problems in the past? If yes how long ago and how was your condition managed at the time?

Is your pain getting:  Better       Worse       Staying the same       Other (please specify below)

Is your pain constant (present all the time with no relief)? Yes  No

<p>On a scale of 0-10 (with 0 being no pain and 10 being the worst pain you have experienced), how would you score your symptoms? Please circle as appropriate</p> <p>Today      1      2      3      4      5      6      7      8      9      10</p> <p>At best      1      2      3      4      5      6      7      8      9      10</p> <p>At worse      1      2      3      4      5      6      7      8      9      10</p>	<p>Have your recent symptoms affected your sleep pattern? And if so, how often is this occurring?</p>
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<p>Are your day to day activities affected by your pain?</p> <p><input type="checkbox"/> Not at all      <input type="checkbox"/> Mildly      <input type="checkbox"/> Moderately      <input type="checkbox"/> Severely</p>	<p>Are you off work because of this problem? If so, how long for?</p>
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<p>Please list any medication you are taking for this current problem (e.g. painkillers/ anti-inflammatories)</p>	<p>Are you unable to care for someone because of this problem? If yes, please give detail</p>
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Thank you for completing this form.  
If you have not heard from us within 4 weeks please contact us on 01273 242054.