

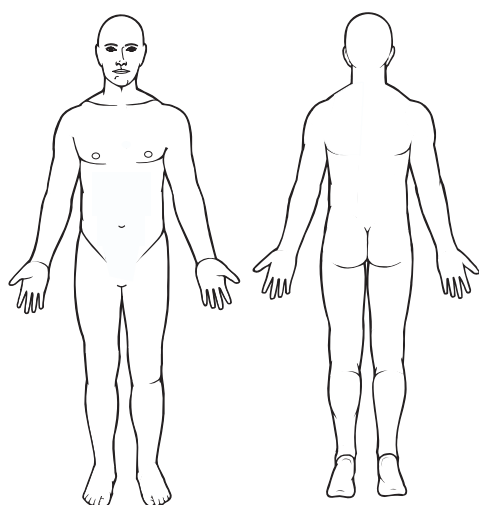
## Patient Completed Self Referral Form

Please complete all parts of this form and hand in or send to local Physiotherapy department

Date		Name		M <input type="checkbox"/>	F <input type="checkbox"/>
Address				Date of Birth:	
Post Code		Occupation			
Telephone	(home)	(work)	(mobile)		
GP Name		GP Address			

Do you have any special requirements? (e.g. interpreter) No  Yes

Please describe:



Please mark on the diagram the location of your problem.

Where is your pain?

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

Please describe your current problem and symptoms below:

How long have you had your current problem? Less than 2 weeks  2 - 6 weeks  7 -12 weeks  If more than 3 months, please state how long:

Is your problem getting? Worse  Better  Not changing

If in pain, how would you describe it? Mild  Moderate  Severe

Is your pain constant (present ALL the time)? No  Yes

Is pain disturbing your sleep?

Yes, difficulty getting to sleep  Yes, woken up from sleep  Yes, unable to sleep at all  No

Are you off work because of this problem? No  Yes  If yes how long:

Are you unable to care for / look after someone because of this problem? No  Yes

Is your problem from an injury sustained during active military service? No  Yes

Are your day to day activities affected by your pain?

Not at all  Mildly  Moderately  Severely

**Please consult your GP URGENTLY or NHS 24 on telephone number: 0800 24 24 24**

if you have recently or suddenly developed:

- difficulty passing urine or controlling bladder / bowels
- numbness or tingling around your back passage or genitals
- numbness, pins and needles or weakness in both legs

**Please inform your GP of this referral if you:**

- have recently become unsteady on your feet
- are feeling generally unwell / fever
- have a history of cancer
- have any unexplained weight loss