

MUSCULOSKELETAL PHYSIOTHERAPY OUTPATIENT SERVICES

PART ONE: Screening form for Self-Referral

PLEASE COMPLETE THIS CHECKLIST TO SEE IF YOU ARE SUITABLE FOR SELF REFERRAL TO PHYSIOTHERAPY

1. Are you under 16 years old?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Are you filling in this form on behalf of someone else?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Have you attended Physiotherapy for the same condition in the last 6 months?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Has your general health changed recently in any way that you haven't discussed with your GP?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Have you had a significant accident recently, for which you have not sought medical advice?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Is this problem to do with;	
• Your breathing/chest	YES <input type="checkbox"/> NO <input type="checkbox"/>
• A neurological problem e.g. Stroke or multiple sclerosis	YES <input type="checkbox"/> NO <input type="checkbox"/>
• Incontinence	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. If you have back pain: Since the pain came on have you developed any of the following symptoms;	
• Problems passing urine	YES <input type="checkbox"/> NO <input type="checkbox"/>
• Problems controlling bowel movements	YES <input type="checkbox"/> NO <input type="checkbox"/>
• Pins and needles or numbness between your legs or around your back passage	YES <input type="checkbox"/> NO <input type="checkbox"/>

If you have answered yes to any of the questions above, you are not suitable to self-refer to Physiotherapy. Please contact your GP Practice to find out who the best person is to speak to or see regarding your problem/condition.

If you have answered 'no' to all the questions above, then please answer the questions below and proceed to PART TWO

Consent to Data Sharing

Do you consent to information recorded by us being shared with other health Care professionals? YES NO

Do you consent to this organisation viewing data relating to your care held on other GP systems? (GP, Out of hours etc) YES NO

Signed:.....

Date:.....

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PART TWO: Patient details for Self-Referral – PLEASE COMPLETE EVERY SECTION

INCOMPLETE OR ILLEGIBLE FORMS WILL NOT BE ACCEPTED

Date		NHS Number (if known)			
Surname		Forename(s)			
Previous Surname		Title (eg Mr, Mrs)		Sex (M/F)	
Date of Birth		Daytime Tel No			
Address		Mobile No			
		Can we leave a message: YES <input type="checkbox"/> NO <input type="checkbox"/>			
		GP Practice			
Post Code					

Please give us a brief description of your problems or symptoms:

How long have you had these symptoms:

Have you had any other interventions or treatments for this problem? (Include dates)

Please complete the following questions:

Did your GP suggest you complete this form? YES NO

Is your problem worsening? YES NO

Are you able to continue your normal activities? YES NO

Is this problem preventing you from working? YES NO

When you have completed PART TWO please send to us by:

Post: Physiotherapy Central Booking Department, Chippenham Community Hospital, Rowden Hill, Chippenham, SN15 2AJ

Email: gwh.communityphysiobookingcentre@nhs.net

Fax: 01249 456516

By hand: to your GP Practice or local physiotherapy department who will forward it onto the Physiotherapy Central Booking Department on your behalf.

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PART THREE: Screening form for self-referral for low back pain and sciatica

PLEASE COMPLETE BOTH SIDES OF THIS FORM IF YOU ARE SELF-REFERRING TO PHYSIOTHERAPY FOR LOW BACK PAIN OR SCIATICA

Please refer to our leaflets for information on our services and let us know which service you would be most interested in.

I would be interested in:

Back Pain Management Classes

- Activate Your Back (one-off class)
- Back class (six week course)

YES NO

YES NO

One-to-One Physiotherapy Appointment

YES NO

Telephone Appointment

YES NO

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PART FOUR: Screening form for self-referral for low back pain and sciatica

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the last 2 weeks tick your response to the following questions:

	Disagree 0	Agree 1
1 My back pain has spread down my leg(s) at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the shoulder or neck at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only walked short distances because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my back pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9. Overall, how bothersome has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9): _____