Sussex MSK Partnership Central

Brighton and Sussex University Hospitals NHS Trust

Physiotherapy Self-Referral Form

Mid-Sussex

Important Notices

If you have **recently** or **suddenly** developed the following with the onset of your lower back pain and / or leg pain.
- *A change in your bladder function or bowel control.*
- *Altered sensation around your genitals or back passage.*
- *Loss of sexual function.*

Do not complete this form and instead **call NHS 111**

If you have **any of the following**:
- *Have any unexplained weight loss.*
- *Are feeling generally unwell/feverish.*
- *Have recently become unsteady on your feet.*

Do not continue with this form but make an appointment with your GP to discuss this referral.

Please do not continue with this form and instead make an appointment to see your GP if you are:
- *Under 16.*
- *Unable to attend the Outpatient Department. If you believe you need domiciliary physio (physiotherapy at home).*
- *Seeking treatment for Neurological or Respiratory disorders.*

We request you do not self-refer within the first 6 weeks of developing a new condition. This is because 86 out of 100 people who develop 'new' symptoms e.g. shoulder pain get better within 6 weeks.
You can visit www.sussexmskpartnership.co.uk for information that may help you manage your symptoms.
However, if you are concerned or your condition is worsening please contact your GP or phone NHS 111.

If you have any queries regarding your referral please contact the BSUH Booking Hub on0300 303 8360 or email OutPatient.BookingCentre@bsuh.nhs.uk

If your symptoms dramatically worsen please see your GP.

Alternatively if your symptoms get better we do not need to see you.

For further information please access our website at: sussexmskpartnershipcentral.co.uk

Your Personal Details(Please Complete this Form in Black Ink)

Today's Date ...../...../.....

Title ..... **Gender**.....

First Name .....

Surname .....

Date of Birth...../...../.....

NHS No......
(available from Medical Letters or Prescriptions)

Address.....

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.....

Postcode .....

Telephone*(please tick preferred number)*

☐ Home .....

☐ Mobile .....

☐ Work .....

Email Address

.....

Are you happy to receive correspondence via email?
Yes ☐ No ☐

Are you happy for a message to be left on your phone?
Yes ☐No ☐

Have you ever been diagnosed with cancer? Yes ☐ No ☐

If yes, please give details: .....

Are you pregnant? Yes ☐No☐	How many weeks pregnant are you?	When is your expected date of delivery? ...../...../.....

If yes, have your symptoms come on since the start of the pregnancy? Yes ☐No☐

Your Referral Details

Which GP Surgery do you belong to?

☐The Brow Medical Centre ☐Cowfold Medical Group ☐Cuckfield Medical Centre

☐Ditchling Health Centre ☐Dolphins Practice ☐Hassocks Health Centre

☐Hurstpierpoint Health Centre ☐Lindfield Practice ☐The Meadows Surgery

☐Newton Surgery ☐Northlands Wood Practice ☐Ouse Valley Practice

☐Park View Health Partnership ☐Sidney West ☐The Vale Surgery

☐Silverdale Surgery / The Avenue Surgery

☐Other (please specify) .....

GP Name.....

Were you advised to complete this form by a clinician? Yes ☐ No ☐

If yes, who advised you to complete this form?

☐GP ☐Specialist Physiotherapist in your GP Practice

☐ Advanced Nurse Practitioner ☐Other

If you selected "Other", please specify .....

About Your Current Problem

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

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

Please tick the box which best describes the area of your problem.

☐ Neck ☐Shoulder ☐ Elbow ☐ Hand / Wrist

☐ Back ☐ Hip ☐ Knee ☐ Foot / Ankle

☐ Bladder or Pelvic Floor ☐ Other (please specify

If you selected "Other", please specify .....

Please tell us about the problem for which you are seeking treatment. Please describe how it started, any pain, weakness or altered sensation.

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How long have you had your current symptoms?

☐Less than 4 weeks ☐4-6 weeks ☐6-12 weeks
☐3-6 months ☐More than 6 months ☐Other

If you selected "Other", please specify .....

Is your pain getting:

☐Better ☐Staying the same
☐Worse ☐Other

If you selected "Other", please specify .....

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

On a scale of 1-10 (with 1 being no pain and 10 being the worst pain you have experienced), how would you score your symptoms? *Please tick as appropriate.*

Today	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐
At best	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐
At worse	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐

Have your recent symptoms affected your sleep pattern? Yes ☐ No ☐
If you answered yes to the question above, how frequently is this occurring?

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Are you off work or unable to care for someone because of this problem? Yes ☐ No ☐

If yes, please give details .....

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Please list any medication you are taking for this current problem (e.g. painkiller/anti-inflammatories).

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Have you been seen by a clinician for this problem? Yes ☐No☐
If yes, who did you see? (GP, Physiotherapist / osteopath, consultant, etc.) and when?

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Have you had a similar problem in the past? Yes ☐No☐
If yes, how long ago and how was it managed? Did you have any treatment or see a specialist? Please give us the details.

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Do you have any special requirements?

☐Sight impairment ☐Hearing impairment
☐Speech impairment ☐Behavioural and Emotional
☐Learning Disability
☐Interpreter (please specify language) .....

☐Other (please specify) .....

Please tell us about any other past medical conditions or ongoing medical issues you are receiving treatment for.

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Please list any other medication you are currently taking.

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In order to get the best out of your appointment, it is helpful to understand what is most important to you (e.g. getting a diagnosis, keeping up with your children/grandchildren, continuing to work, etc.).
Please let us know what matters most to you at the moment so we can do our best to support you.

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Thank you for completing this Self-Referral Form.

Please return this form to your GP practice.

Please note that it is<u>not</u> possible to hand in this form to the booking centre

However, you can **post** it to:
Royal Sussex County Hospital, Outpatient Booking Centre, Lower Ground Floor, Elliot House, Eastern Road, BN2 5BE

Once we have received your form, it will be looked at by a senior clinician. Depending on the information you have supplied we will contact you to organise a telephone or face to face appointment for further assessment.

If you have any queries regarding your referral please contact the BSUH Booking Hub on0300 303 8360 or email <u>OutPatient.BookingCentre@bsuh.nhs.uk</u>