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| **Self-Referral to Musculoskeletal Physiotherapy** | | | | |
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| **Date of Birth** (DD/MM/YY) |  | **NHS Number** |  | |
| **Title** |  | **Gender** |  | |
| **Surname** |  | **First Name** |  | |
| **Preferred Treatment Location** | |  | | |
| **Home Address** | | | | |
| **House Number or Name** |  | | | |
| **1st Line** |  | **Town** | |  |
| **2nd Line** |  | **Postcode** | |  |
| **Email Address** |  | | | |
| **Preferred Phone Number** |  | **Alternative Phone Number** | |  |
| **Can we leave a message?** | |  | | |
| **Registered GP Practice**  If your surgery is not listed, please contact your GP and **do not complete this form** | | BIDFORD HEALTH CENTRE | | |
| **GP Name** |  | | | |
| **Is an interpreter required?** |  | **If yes, what language** | |  |
| **Reason for Referral** Please note we do not accept referrals if the problem has been treated with Physiotherapy in the last 6 months, or for OT hand and wrists assessment and treatment, please contact your GP for further guidance. | | | | |
| **Where is your problem?** Only one |  | **Is your problem worsening?** | |  |
|  | | | | |
| **How long have you had the problem?** | |  | | |
| **Have you had the problem before?** |  | If yes, how long ago? | |  |
| **Did you have Physiotherapy for it?** |  | **Was it beneficial?** If yes, please list what treatment was received below. If no, do not complete this referral and see your GP | |  |
|  | | | | |
| **Do you know what caused your problem?** If yes, describe below | | | |  |
|  | | | | |
| **Are you seeing a consultant for this problem?** | | | |  |
| If yes, please provide their name, speciality & where are they work (SWFT or other NHS Trust)? | | | | |
|  | | | | |
| **Please list any investigations into the problem e.g. x-rays, scans, bloods etc. below** | | | | |
|  | | | | |
| **Are you able to carry out normal activities?** |  | If no, what in particular are you struggling with? Please choose from the list | |  |
| **Are you currently off work because of your problem?** |  | If yes, how long have you been off? | |  |
| **Please list any medication you are currently taking** including any allergies | | | | |
|  | | | | |
|  | | | | |
| **Please ensure the form is fully complete before submitting. Incomplete referrals maybe rejected.** | | | | |
|  | | | | |
| **Email your referral to:** [therapies@swft.nhs.uk](mailto:therapies@swft.nhs.uk?subject=Staff%20Self%20Referral) | | | | |
| Or post to Therapies Department, Warwick Hospital, Lakin Road, Warwick CV34 5BW | | | | |
| Please note: It is your responsibility to book your initial appointment. You will be discharged if you do not call to book it within 4 weeks of submitting this form. | | | | |
|  | | | | |



**Self-Referral Criteria- paper completion option**

Please read the following criteria prior to completing to ensure self-referral is the best option for you.

* **You must be over 16 years old and registered with a South Warwickshire GP. (A GP, consultant or other healthcare professional referral is required for children under 16.)**
* **Please consult NHS 111 or GP urgently if you have recently or suddenly developed difficulties passing urine or controlling bladder/bowels, numbness or tingling around your back passage or genitals, numbness/pins and needles or weakness in both legs.**
* **We will treat you for one condition only. This is to keep waiting times down and improve the quality of your care.**
* **It is important that you do not self-refer if you have any of the following signs or symptoms without consulting your GP first:** 
  + Changes in your bladder and bowel habits
  + A hot swollen joint
  + Constant severe pain and you are unable to find relief
  + Weakness, pins and needles, loss of feeling
  + Unexpected weight loss
* **Outpatient Physiotherapy will NOT treat the following (please contact your GP or relevant consultant who will be required to refer you)** 
  + Patients in their own homes (i.e. are housebound in the short or long term)
  + Respiratory conditions
  + Neurological conditions
  + Post amputation (requires a specialist referral)
  + Women’s health problems (except pregnancy related pelvic and/or back pain)
  + Men’s health problems
  + Patients who have undergone extensive, complicated surgery, as defined by the operating consultant for an orthopaedic or rheumatological condition in which requires specialist intervention
  + Patients who have undergone surgery to the area in the last 6 months (please contact your consultant)
* **Please note:**
* If you require assessment or treatment for your hand or wrist please go back to your GP/Consultant for a referral to the Hand Therapy team.
* You are unable to access this service within 6 months if it is for the same condition.
* Depending on your condition and needs, you may be offered an initial assessment with advice and guidance. For those requiring further treatment sessions, this will be discussed with you at your initial appointment where you and your physiotherapist will set jointly agreed goals.
* If you fail to attend your appointment and give no notice of cancellation you will be discharged.

**Please phone to book your appointment in 5 working days’ time on 01926 600818 option 5**