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| **Musculoskeletal physiotherapy outpatient services** |
| **PART ONE: Screening form for Self-Referral** |

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| PLEASE COMPLETE THIS CHECKLIST TO SEE IF YOU ARE SUITABLE FOR SELF REFERRAL TO PHYSIOTHERAPY |
| 1. Are you under 16 years old? |  [ ]  Yes [ ]  No |
| 2. Are you filling in this form on behalf of someone else? |  [ ]  Yes [ ]  No |
| 3. Have you attended Physiotherapy for the same condition in the last 6 months? |  [ ]  Yes [ ]  No |
| 4. Has your general health changed recently in any way that you haven’t discussed with your GP? |  [ ]  Yes [ ]  No |
| 5. Have you had a significant accident recently, for which you have not sought medical advice? |  [ ]  Yes [ ]  No |
| 6. Is this problem to do with; |  |
| * Your breathing/chest
 |  [ ]  Yes [ ]  No |
| * A neurological problem e.g. Stroke or multiple sclerosis
 |  [ ]  Yes [ ]  No |
| * Incontinence
 |  [ ]  Yes [ ]  No |
| 7. If you have back pain: Since the pain came on have you developed any of the following symptoms; |  |
| * Problems passing urine
 |  [ ]  Yes [ ]  No |
| * Problems controlling bowel movements
 |  [ ]  Yes [ ]  No |
| * Pins and needles or numbness between your legs or around your back passage
 |  [ ]  Yes [ ]  No |
| **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 [ ]  NoDo 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:** P.T.O. |  |

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| **PART TWO: Patient details for Self Referral –** PLEASE COMPELTE EVERY SECTION |
| **INCOMPLETE OR ILLEGIBLE FORMS WILL NOT BE ACCEPTED** |
| Referral Date: |  | NHS No |  |
| Surname |  | Forenames |  |
| Previous Surname |  | Title |  | Sex |  |
| Date of Birth |  | Daytime Tel No |  |
| Address |  | Mobile No |  |
| Email Address |  |
| Can we leave a message: | [ ]  Yes [ ]  No |
| Registered GP |  |
| Post Code |  | GP Practice |  |

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| 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**: wilts.mskphysiobooking@HCRGCareGroup.com**By hand**: to the physiotherapy department or to your GP practice who will put in internal post 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)
 | [ ]  Yes [ ]  No |
| * Back class (six week course)
 | [ ]  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

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| **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 | [ ]  | [ ]  |
| 2 | I have had pain in the shoulder or neck at some time in the last 2 weeks | [ ]  | [ ]  |
| 3 | I have only walked short distances because of my back pain | [ ]  | [ ]  |
| 4 | In the last 2 weeks, I have dressed more slowly than usual because of back pain | [ ]  | [ ]  |
| 5 | Its not really safe for a person with a condition like mine to be physically active | [ ]  | [ ]  |
| 6 | Worrying thoughts have been going through my mind a lot of the time | [ ]  | [ ]  |
| 7 | I feel that my back pain is terrible and its never going to get any better | [ ]  | [ ]  |
| 8 | In general, I have not enjoyed all the things I used to enjoy | [ ]  | [ ]  |
|  |  |  |  |
| 9 | Overall, how bothersome has your back pain been in the last 2 weeks? |
|  | Not at all [ ]  0 | Slightly [ ]  0 | Moderately [ ]  0 | Very much [ ]  1 | Extremely [ ]  1 |

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| **Total score (all 9):**  |       | **Sub Score (Q5-9):**  |       |