

MUSCULOSKELETAL PHYSIOTHERAPY ROUTINE SELF-REFERRAL FORM

We are not an emergency service, if you suspect you require urgent attention please consult your GP, 111 or A&E

We do not accept self-referral for recent fractures or post-operative rehab, unless a clinician's referral is attached.

Please ensure you fill this form for your main problem only. If you have more than two problems kindly request your GP to refer you for Physiotherapy.

This service is for people who are **16 or** **over** with musculoskeletal problems, such as muscle and joint pain, sports injuries, back or neck pain, sprains and strains.We are also able to assess many pelvic health conditions.

**If you are under 16**:please contact your GP and they can refer you to the paediatric physiotherapy team as appropriate.

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|  | **IMPORTANT:**  **Please speak to your GP before self-referring if you have any of the following** |
|  | * unexplained weight loss * history of cancer * night pain * fever or night sweats * unsteady on feet or pins & needles/ numbness in both arms or in both legs |
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# How do you refer yourself for physiotherapy advice?

By ***filling in this form*** and sending it to us.

1. Email the filled form to **s1.dynamichealth@nhs.net** OR
2. Post the completed form to the address below:

**MSK Physiotherapy Department, City Care Centre, Thorpe Road, Peterborough, PE3 6DB**

Please complete each page of the form in full so that we are able to direct and help you with your problem

If you require assistance completing the form please contact 0300 555 0123 (charged at local rate)

(Please note - information sent by email may not be secure)

What happens once we have received your self-referral form?

Once we have received your referral, a physiotherapist will review the information to ensure your condition is appropriate for physiotherapy. You will then be added to the waitlist for a telephone or video consultation.

Our experienced physiotherapists provide personalised advice and exercise plans via telephone or video, which enable most patients to recover or improve their condition at home.

In some cases a face to face appointment may be offered if deemed appropriate by the physiotherapist.

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| If a face-to-face appointment is deemed necessary please choose which clinic location would you like to attend   |  |  |  | | --- | --- | --- | | **CAMBRIDGE:** |  | MSK Physiotherapy Department, Brookfields Hospital, Brookfields Campus, 351 Mill Road,  Cambridge,  CB1 3DF | | **DODDINGTON:** |  | MSK Physiotherapy Department, Doddington Community Hospital, Benwick Road, Doddington, PE15 0UG | | **ELY:** |  | MSK Physiotherapy Department, Princess of Wales Hospital, Lynn Road, Ely, CB6 1DN | | **HUNTINGDON:** |  | MSK Physiotherapy  Department, Hinchingbrooke  Hospital, Hinchingbrooke Park, Huntingdon, PE29 6NT | | **PETERBOROUGH:** |  | MSK Physiotherapy Department, City Care Centre, Thorpe Road, Peterborough, PE3 6DB | | **WISBECH:** |  | MSK Physiotherapy Department, Rowan Lodge, North Cambridgeshire Hospital, The Park, Wisbech, PE13 3AB | |

We may send SMS messages for appointment reminders and to relay any other useful information including asking for your feedback. Please ensure we have your correct mobile phone number should you wish to receive these.

We may send correspondence to you via email including personal, sensitive data. If you agree to this form of communication, we will send a verification to your email address before any information can be sent. Once this has left our secure NHS account, the security of this information would be your responsibility.

You may have already received a verification e-mail from your GP. If this is the case, you will not receive another from us as this process has already been completed.

It is also possible to have your appointment via video consultation, for which we will require an up-to-date mobile number and/or email address and you will need a video enabled device.

I/We would like to receive email correspondence including sensitive information:        **YES  / NO** 

I/We consent to receiving voicemail messages:     **YES  / NO**

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| **Authorisation by Patient/Parent/Carer.**  **PLEASE TYPE OR SIGN IN THE BOXES BELOW TO INDICATE YOUR CONSENT**  Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Parent/Carer  Name in capitals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mobile telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Full Name (First and Surname):** | | **Date of Birth:** | |  |
|  | | **Gender:** | |  |
| **Email Address:** | | **Contact Tel Home:**  **Mobile:** | |  |
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|  | | **Main Language:** | |  |
| **Address:** | | **Interpreter Required:** | | Yes  No |
|  | | **Postcode:** | |  |
|  | | **Date of Referral:** |  | |
| **NHS Number:** | **GP Surgery:** | **GP Address:** | | |
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| **Do you have any disability or require special adjustments?**  Hearing impairment  Visual impairment  Learning Disability  Mobility  Speech  Behaviour and Emotional  Dementia  Mental Health  Require a carer to be present  No disabilty  Prefer not to say | | **Ethnicity:**  Asian/British Asian  Black/British Black  Mixed  White  Other  Prefer not to say | | |
|  | | **Sexual Orientation:**  Bisexual  Heterosexual  Homosexual  Other  Prefer not to say | | |
| **Have you received physiotherapy advice from DynamicHealth for this condition before?** | | No  Yes – Please state when: | | |

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| **SECTION A: CONTACT DETAILS – PLEASE COMPLETE ALL DETAILS IN BLOCK CAPITALS** |

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| **SECTION B: REASON FOR SELF REFERRAL** |

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| **Which body part is affected or where is your problem? *(please choose your MAIN problem below)***  1. Neck  a. Headaches  b. Neck pain  c. Neck with arm pain above elbow  d. Neck and arm pain below elbow    2. Middle Back  3. Lower Back  a. Low back pain  b. Low back with leg pain above knee  c. Low back with leg pain below knee      4. Shoulder  a. Right  b. Left  5. Elbow  a. Right  b. Left  6. Wrist  a. Right  b. Left  7. Hand  a. Right  b. Left  8. Hip  a. Right  b. Left  9. Knee  a. Right  b. Left  10. Ankle  a. Right  b. Left  11. Foot  a. Right  b. Left  12. Pelvic Health  a. Bladder  b. Bowel  c. Prolapse  d. Pelvic/Genital pain  e. Pelvic girdle pain in pregnancy/post-natal  **If you have a second problem please choose below ( If applicable)**  *If yes, Please copy from the above list [1-12] with sub options here*  ***If you have more than two problems kindly request a GP referral.***   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | |  | |  | |  | |  | |  | |  |  | |  | |  | |  | | |  |  | |  | |  | |  | | |  |  | |  | |  | |  | | |  |  | |  | |  | |  | |   **2.** What type of symptoms are you getting? *(Please tick)*  Pain  Weakness  Abnormal Sensation *e.g. numbness, pins and needles/tingling*  Swelling  Stiffness  Cramps  **3**. When did this problem start?  Less than 1 week  1 - 6 weeks  6 weeks-3 months  3 - 6 months  6 months - 1 year  >1 year |  |
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**Please give us a brief description of the MAIN PROBLEM for which you are self-referring:**

**df**

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| **Review this information if your referral is for a VERY SEVERE episode of low back and / or Sciatica (pain in your leg/s referred from your back).**  Associated with the **VERY SEVERE** episode of low back and / or Sciatica, have you recently noticed a change in the following: |
| 1. **Altered/loss sensation (numbness) in your vaginal / genital area or back passage?** *(i.e. noticed any numbness when you wipe yourself after going to the toilet)* |
| 1. **Change in your bladder or bowel function?** *(i.e. leaking of urine / increased frequency of passing urine / being unable to pass urine / loss of control of bladder/bowel )* |
| 1. **Changes in sexual function?** *(i.e. unable to achieve and maintain an erection / altered sensation during sexual intercourse)* |
| If any of the above statements apply to you AND this is associated with a VERY SEVERE episode of low back pain and/or sciaticaDO NOT CONTINUE ON THIS FORM.Please contact emergency services immediately such as 111 to guide you if you need to attend A&E |

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| Have you consulted your GP for this problem Yes  No  Have you had any physiotherapy for this condition recently or for a previous episode**?** Yes  No  If answered yes, Did it help? Yes  No  Have you had any recent investigations? (i.e. X-Ray / Blood Tests/ Scan) Yes  No |
| Have you had surgery in the last 6 weeks and require post-operative care Yes  No  *If yes, please attach consultant's or GP's referral letter - We do not accept any recent post fracture or post-operative referrals without a clinician's referral.*  Did your symptoms start following a recent major trauma or injury Yes  No  Since your symptoms began, do you think they are  Improving  Same  Worsening  Good/bad days    Are you the main carer for friend / family member? Yes  No    If yes, are you unable to care for your friend/family member due to this pain/symptom? Yes  No  Due to your pain are you getting less than 4 hours sleep per night? Yes  No  Are you currently signed off work as a result of your symptoms? Yes  No  If yes, how long have you been off work due to these symptoms?  Less than 1 week  1 – 4 weeks  1- 6 months  >6 months |

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| **Relevant Medical History:**  *Please select Yes or No for* ***ALL*** *of the following:* | |
| |  |  |  | | --- | --- | --- | | **Condition** | Yes | No | | Heart Problems |  |  | | Lung Problems |  |  | | Diabetes |  |  | | Epilepsy |  |  | | Hypertension |  |  | | Rheumatoid Arthritis |  |  | | TB |  |  | | Osteoporosis |  |  | | Cancer (Past / Current) |  |  | | Anxiety/Depression |  |  | | Headaches |  |  | | |  |  |  | | --- | --- | --- | | **Condition** | Yes | No | | Smoker (Past / Present) |  |  | | Alcohol consumption > 14 Units per week |  |  | | Pregnant |  |  | |

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| **SECTION C: The Keele STaRT MSK Screening Tool** |

For questions 1-9, think about just the last two weeks:

***Pain intensity***

1) On average, how intense was your pain [where 0 is “no pain” and 10 is “pain as bad as it could be”]?

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| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | | **9** | **10** |
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*Please cross one box for each question below*

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|  | | | Yes | No |
| 2) Do you often feel unsure about how to manage your pain condition? | | |  |  |
| 3) Over the last two weeks, have you been bothered a lot by your pain? | | |  |  |
| 4) Have you only been able to walk short distances because of your pain? | | |  |  |
| 5) Have you had troublesome joint or muscle pain in more than one part of your body? | | |  |  |
| 6) Do you think your condition will last a long time? | | |  |  |
| 7) Do you have other important health problems? | | |  |  |
| 8) Has pain made you feel down or depressed in the last two weeks? | | |  |  |
| 9) Do you feel it is unsafe for a person with a condition like yours to be physically active? | | |  |  |
| 10) Have you had your current pain problem for 6 months or more? | | |  |  |
| Cambridgeshire Community Services NHS Trust: delivering excellence in musculoskeletal services and pelvic health physiotherapy across Cambridgeshire and Peterborough |  |