Physiotherapy Self Referral Form.

Please fill out ALL 3 pages of this form and ensure you use BLOCK CAPITALS.

The self referral service is not available to under 16's or for neurological, respiratory, obstetric and gynecological problems.

<table>
<tr><td colspan="2">Full Name</td></tr>
<tr><td colspan="2">Address

Post Code</td></tr>
<tr><td>Date of Birth</td><td rowspan="3">Your Contact Telephone Numbers

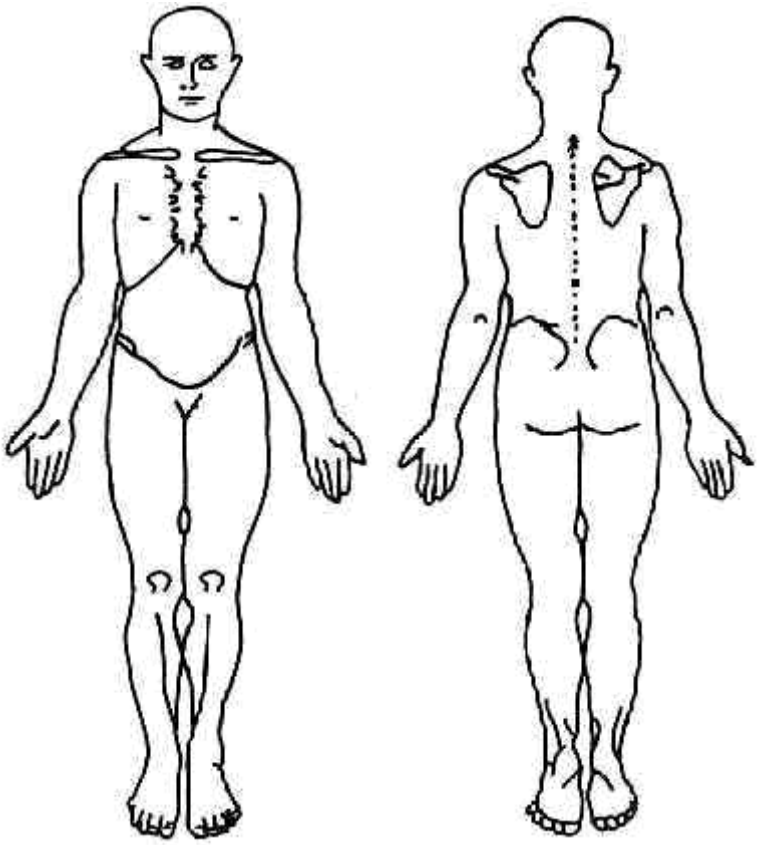
Home Tel

Work Tel

Mobile</td></tr>
<tr><td>GP Name

Practice</td></tr>
</table>

Indicate on the pictures where you get your symptoms. For example pain, pins and needles, numbness.



Please return this form to: **Physiotherapy Department, Withybush General Hospital, Fishguard Road, Haverfordwest, SA61 2PZ**. Tel: 01437 773260 **OR** if you are wish to come to one of our 'drop in clinics', bring a completed copy of the form to the clinic.

Please give a brief description of your symptoms, or why you wish to see a physiotherapist.
How long have you had the problem? Days Weeks Months Years
How did it start? (Eg: Just came on, injury, fall, long term problem etc)
Are you in pain all the time or does it come and go? Pain all the time ☐ Comes and goes ☐ How often do you have the pain? ……
What makes the pain WORSE?
What makes the pain BETTER?
Is it generally worse? Tick answer that applies most In the morning ☐ in the afternoon ☐ in the evening ☐ at night ☐ no pattern ☐
Are you off work or unable to care for a dependent because of this problem? Yes ☐ No ☐ (If yes, please give details)
Please indicate any activities you are unable to do because of this problem.
If this is a problem with your joints: Does the joint: Give way Yes ☐ No ☐ , Click Yes ☐ No ☐ , Lock Yes ☐ No ☐ , Swell Yes ☐ No ☐
Please list **All** of the medication you are taking.
What are your expectations from physiotherapy?

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Since the onset of this problem, do any of the following apply to you? If you have the symptoms please tick 'Yes' If you do not have the symptoms please tick 'No'	
	Yes No
Severe pain at night that wakes you.	☐ ☐
Double vision	☐ ☐
Problems swallowing	☐ ☐
Does sneezing change your symptoms	☐ ☐
Tinnitus	☐ ☐
Nausea	☐ ☐
Headache	☐ ☐
Facial Pain	☐ ☐
Do you have problems with speaking	☐ ☐
Do you have problems with walking	☐ ☐
Pins and needles anywhere	☐ ☐
Numbness anywhere	☐ ☐
Dizziness	☐ ☐

Since the onset of this problem do any of the following statements apply	
Bladder problems – Difficulty in passing water or a feeling that you can not empty your bladder.	Yes No ☐ ☐
Bowel problems – a loss of bowel control (soiling yourself)	☐ ☐
Unexplained weight loss	☐ ☐

General Health	Yes No		Yes No		Yes No
Rheumatoid arthritis	☐ ☐	History of cancer	☐ ☐	Diabetes	☐ ☐
High blood pressure	☐ ☐	Thyroid Problems	☐ ☐	Heart problems	☐ ☐
Low blood pressure	☐ ☐	Major Surgery	☐ ☐	Pacemaker	☐ ☐

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Lung / Breathing problems	☐ ☐	Osteoporosis	☐ ☐	Epilepsy	☐ ☐
Fractures / Broken bones	☐ ☐	Are you pregnant	☐ ☐	Allergies	☐ ☐
If you have answered YES to any of the above or have any other medical problems, please provide further details here:					

Patient signature: Date:

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