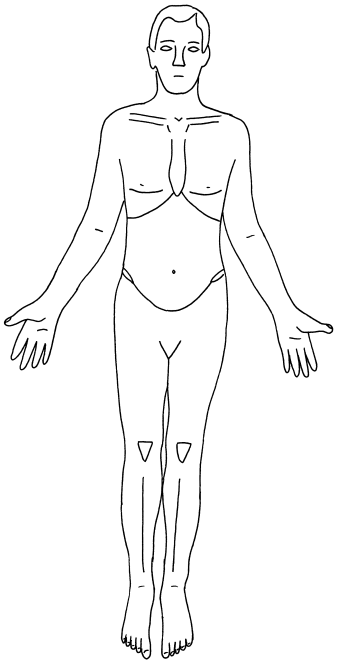
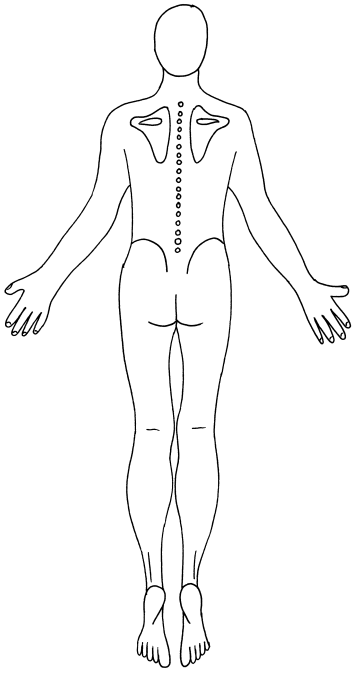
| Medication | YES | NO |
|---|---|---|
| Steroids | | |
| Anticoagulants | | |

**Please list ALL the medication you are taking**

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





***Please make sure you have filled in all parts of the form***

*Signature* _____

*Date* _____

**Please return this form to:**
**Physiotherapy Appointments Officer**
**Physiotherapy Department, Neath Port Talbot Hospital, Baglan Way, Baglan, SA12 7BX**

**If your symptoms should change, please contact the physiotherapy department or see your GP**

# Physiotherapy Service Self Referral Form

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

**This form should only be used for patients wishing to have physiotherapy for musculoskeletal problems (back/neck pain, joint pain, soft tissue injuries)**

**If you are under the age of 18, or wish to have treatment for a lung or breathing problem, a neurological problem or an obstetric/gynaecological problem, please see your Health Practitioner**

**This form will be used to determine how your referral is processed. Please ensure you:**
- **Use a BLACK Pen**
- **Use BLOCK CAPITALS**
- **Complete ALL sections of the form**

**Incomplete forms will be returned to you which will cause a delay in the management of your problem. Once received, the form will be reviewed and placed on a waiting list.**

Full Name

Address

Post Code

Date of Birth: ___/___/_____.

GP Name _____

Practice _____

_____

Your Contact Telephone Numbers

Home _____ Can we leave a message? Yes / No

Work _____ Yes / No

Mobile _____ Yes / No

Please give a brief description of your symptoms, or why you wish to see a physiotherapist

How long have you had this problem? Days ____. Weeks ____. Months ____. Years ____.

How did it start? *(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 ☐

Have you had treatment / physiotherapy for this condition in the past? **Yes / No**
*(if YES, please give details)*

Have you had any X-rays or other tests? **Yes / No** *(if YES, please give details/ results)*

Have you had this problem before? **Yes / No** *(if YES, please give details)*

*If this is a problem with your joints:*

| Does your joint? | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Give Way | | | Click | | | Lock | | | Swell | |

Are you off work or unable to care for a dependant because of this problem? **Yes / No**
*(if yes, please give details)*

Please indicate any activities you are unable to do because of this problem

What are your expectations from Physiotherapy?

**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 | | YES | NO |
|---|---|---|---|---|---|
| Severe Pain at Night (Wakes you up) | | | Double vision | | |
| Does coughing change your symptoms | | | Problems Swallowing | | |
| Do you have problems with speaking | | | Does Sneezing change your symptoms | | |
| Do you have problems with walking | | | Tinnitus | | |
| Pins and Needles anywhere | | | Nausea | | |
| Numbness Anywhere | | | Facial Pain | | |
| Dizziness | | | Headache | | |

If you have ticked **YES** to any of these symptoms, and you **HAVE NOT** seen a doctor for this symptom, please call **Physio Direct** (01792 487453) OR **NHS Direct** on (0845 45 46 47)

**DO NOT send in this form until you have sought further advice**
*Please tick box to confirm you have sought further advice if indicated* ☐

**SINCE THE ONSET OF THIS PROBLEM Do any of the following Statements apply?**

| | YES | NO |
|---|---|---|
| **Bladder Problems—a difficulty in passing water or feeling you cannot empty your bladder** | | |
| **Bowel problems—a loss of bowel control (soiling yourself)** | | |
| **Unexplained weight loss** | | |

If you have ticked **YES** to any of these symptoms, and you **HAVE NOT** seen a doctor for this symptom, it is essential you arrange an **URGENT** appointment with your **GP** or call **NHS Direct** on (0845 45 46 47) or attend your local **A&E Department**

**DO NOT SEND IN THIS FORM UNTIL YOU HAVE SOUGHT FURTHER ADVICE**

| 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 | | |
| 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:**