Wiltshire HEALTH AND CARE

NHS

MUSCULOSKELETAL PHYSIOTHERAPY OUTPATIENT SERVICES

PART ONE: Screening form for Self-Referral

PLEASE COMPLETE THIS CHECKLIST TO SEE IF YOU ARE SUITABLE FOR SELF REFERRAL TO PHYSIOTHERAPY

Question	Answer
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;	YES ☐ NO ☐
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;	YES ☐ NO ☐
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 FOR SELF-REFERRAL 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 ☐ NO ☐

Do 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:** <Today's date>

Wiltshire HEALTH AND CARE

NHS

MUSCULOSKELETAL PHYSIOTHERAPY OUTPATIENT SERVICES

PART TWO: Patient details for Self-Referral – PLEASE COMPLETE EVERY SECTION

INCOMPLETE OR ILLEGIBLE FORMS WILL NOT BE ACCEPTED

Date	<Today's date>	NHS Number	<NHS number>		
Surname	<Patient Name>	Forename(s)	<Patient Name>		
Previous Surnames		Title	<Patient Name>	Sex	<Gender>
Date of Birth	<Date of birth>	Daytime Tel No	<Patient Contact Details>		
Address	<Patient Address>	Mobile No	<Patient Contact Details>		
		Can we leave a message: YES ☐ NO ☐			
Post Code	<Patient Address>	GP Practice	<GP Details>		

Please give us a brief description of your problems or symptoms:

<Event Details>

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:

Question	Answer
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 to:
Physiotherapy Central Booking Department, Chippenham Community Hospital, Rowden Hill, Chippenham, SN15 2AJ
Or
Physiotherapy Department, Salisbury District Hospital, Salisbury, Wilts. SP2 8BJ

Email: WCCG.routinesarumreferralcentre@nhs.net
By hand: to your GP Practice or local physiotherapy department who will forward it onto the Physiotherapy Central Booking Department on your behalf.

Wiltshire HEALTH AND CARE

NHS

Musculoskeletal physiotherapy outpatient services

PART THREE:
DO NOT COMPLETE UNLESS YOU HAVE LOW BACK PAIN AND/OR SCIATICA

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 indicate which service you think you would be most interested in. Our leaflets give more for information on our services I would be 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 ☐

PART FOUR: Screening form for self-referral for low back pain and sciatica

The Keele STarT Back Screening Tool

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	It's 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 **it's 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	Slightly	Moderately	Very much	Extremely
☐ 0	☐ 0	☐ 0	☐ 1	☐ 1

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