Whittington Health NHS

DATE OF REFERRAL:

Patient Self Referral to Musculoskeletal Physiotherapy

This form should only be used for patients (over the age of 18) wishing to have physiotherapy for musculoskeletal problems (back/neck pain, joint pain, soft tissue injuries).

Tel: 020 3316 1111

Please provide Email:	**Please provide Mobile No:**
***I confirm that I am happy to receive information by email** ☐ **Yes** ☐ **No**	***I confirm that I am happy to receive information by text** ☐ **Yes** ☐ **No**

****Email address and mobile number supplied will not be used for any other purposes or shared with any other parties***

Please complete ALL sections of the form, incomplete forms will be returned which will cause a delay in the management of your problem. NO appointments can be booked until a FULLY COMPLETED form has been received. Once completed this form can be:

Emailed: arti.centralbooking@nhs.net

Posted: ***The Central Referral Management Team – 338-346 Goswell Road London EC1V 7LQ***

Handed In To: ***The Physiotherapy Reception at St Ann's Hospital, St Ann's Road, London, N15 3TH***
Bounds Green Health Centre, 1a Gordon Road, London, N11 2PF
Lordship Lane Health Centre, 239 Lordship Lane, London, N17 6AA
Hornsey Central Neighbourhood Health Centre, 151 Park Road, London, N8 8JD
Whittington Hospital, Highgate Hill, London, N19 5NF
Holloway Community Health Centre, 11 Hornsey Street, London N7 8GG
Finsbury Health Centre,17 Pine Street, London EC1R 0LP

Surname:	**First name:**	**Gender:**	**Date of Birth:**
Address:		**Post code:**	
Daytime Tel No:		**NHS No:** **Hospital No:**	
Is an interpreter required? Yes ☐ No ☐		**If Yes, what language:**	
Optional for data monitoring purposes only. **How would you describe your ethnic origin?**		**Next of kin:** **Telephone No :** **Contact Address:**	

GP'S DETAILS

Name: Dr Alan Trosser	**Have you consulted your GP about this problem?** **Yes ☐ No ☐**
Practice: HIGHBURY GRANGE HTH.CTR. 1-5 HIGHBURY GRANGE LONDON N5 2QB	**If Yes, what did they recommend:**
Tel No: 020 72262462	

Give a brief description of your problem including how it started. *(please only refer for one condition)*

Area of pain / How it started / Any pins & needles or numbness – if so, where?

How long have you had this problem?

Less than 2 weeks ☐	**2 – 6 weeks ☐**	**More than 6 weeks ☐**	**More than 1 year ☐**

Is your problem:

Getting better	**Getting worse**	**Staying the same**

Have you had any investigations for this problem? (E.g. Scans, X-rays, Blood tests)

Yes ☐	No ☐
If Yes, please give details:	

Name:	**Date of Birth:**

General Health - Please tick if you have any of the following:

Lung problems	☐	**SINCE THE ONSET OF THIS PROBLEM Do any of the following apply to you? If you have the symptoms please tick**	
Heart Problems	☐		
Epilepsy	☐		
Osteoarthritis	☐	***Unexplained* Weight Loss**	☐
Rheumatoid Arthritis	☐	**History of Cancer**	☐
Osteoporosis	☐	**Fever or Night Sweats**	☐
Diabetes	☐	***Unexplained* Bladder or Bowel problems**	☐
Surgery / Operations	☐	**Unremitting Night Pain**	☐
Poor General Health	☐	**Unsteady on feet**	☐
Previous Fractures	☐	If you have ticked 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 attend your local **A&E Department** **DO NOT SEND IN THIS FORM UNTIL YOU HAVE SOUGHT FURTHER ADVICE**	
Current or Past Pregnancy	☐		
Any Major Illness	☐		

If Yes to any, please give details:

Please list any Medicine you are taking:

Employment status:

Employed ☐	Unemployed ☐	Retired ☐	Student ☐	Carer ☐

Please give details:

Any activities you do (E.g. Sports, Gym, Hobbies). Please give details:

Due to your current problem you are unable to:

Work ☐	Participate in activity/sport ☐	Care for dependent	Other

Please give details:

Your perception:

What are your expectations from Physiotherapy?