Tameside and Glossop Integrated Care
NHS Foundation Trust

MSK Physiotherapy Referral Form

PLEASE COMPLETE ALL SECTIONS ON BOTH SIDES - INCOMPLETE FORMS WILL BE RETURNED

Name:	**Today's Date:**
Date of Birth: **Age:**	**GP Name:**
NHS Number:	**GP Practice:**
Address:	**GP Telephone Number:**
	Do you require an interpreter? Yes☐ No☐ If yes, which language? ___________________
Telephone: **Mobile :** **Daytime :**	(Please note family members are not able to interpret at your appointment, we will arrange an interpreter for you)

Which body part do you require physiotherapy for?

What are your symptoms in this body part?

☐ Pain ☐ Pins and Needles ☐ Stiffness

Other (please give details) ____

How long have you had this problem?

____

Have you had an injury or operation on this body part?

☐ Yes - injury ☐ Yes - operation ☐ No

If Yes, when? ___________________________

What happened/what operation did you have? ___________________________________

____

Are you off work now due to this problem? ☐ Yes ☐ No ☐ Not applicable

If yes, how long have you been off work for? _______________________________________

Are you struggling to care for a dependent due to this problem? ☐ Yes ☐ No

Have you seen your GP about this problem? ☐ Yes ☐ No

Have you had treatment for this problem before? ☐ Yes ☐ No

If yes: ☐ Physiotherapy When ________________ Where ________________

☐ Consultant When ________________ Where ________________

☐ Other (please state) ______________________ When _______________

Have you had any investigations for this problem?

☐ Scan ☐ X- Ray ☐ Blood Tests ☐ Other (please state)_____________________

If so please **include a copy** of the results with this form. If you do not have this please **bring a copy** of the report to your physiotherapy appointment (your GP should have this).

Only answer this question if you have Low Back Pain.

Do you have any difficulties passing or controlling urine? ☐ Yes ☐ No

If yes, what problem do you have with your bladder? ___________________________________

How long have you had this? _________________ Have you told your GP about this? ☐ Yes ☐ No

Have you lost weight in the last 3 months without trying? ☐ Yes ☐ No

If yes, how much? ________________________ Have you told your GP about this? ☐ Yes ☐ No

Your Medical History – Please tick any that apply and give details

☐ I have no medical problems

☐ Heart Problem ____

☐ Lung Problem ____

☐ Diabetes ____

☐ Cancer ____

☐ Operations ____

☐ Allergies ____

☐ Other medical conditions ____

Please List Your Current Medication

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

This form has been completed by:

☐ Myself ☐ GP ☐ Consultant ☐ Other (please state) _________________

Where do you want to attend for Physiotherapy?

☐ **Ashton Primary Care Centre** 193 Old Street, Ashton Under Lyne, OL6 7SR – 0161 3427000 Fax 0161 3427030

☐ **Glossop Primary Care Centre** George Street, Glossop, SK13 8AY – 01457 850550 Fax 01457 850572

☐ **Either of the above** (I would like the shortest waiting time)

PLEASE RETURN THIS FORM TO CENTRAL BOOKING AT :- **Ashton Primary Care Centre**
193 Old St
Ashton
OL6 7SR

OR EMAIL TO :- tga-tr.tg-mskphysioreferrals@nhs.net