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| If you are **over 16** and have a **registered GP** in **Southampton or Portsmouth City** you are able to refer to the MSK Physiotherapy Service for a range of muscle and joint problems including back/neck pain, joint pain, strains and sprains.  |
| Important information below, please read before you start to complete this Self Referral form. |
| * Difficulty passing urine or controlling bladder/bowels.
* Numbness or tingling around your back passage or genitals.
* Numbness, pins and needles or weakness in both legs.
* Are feeling generally unwell/fever.
* Have any unexplained weight loss.
* Have a history of cancer.
* Have recently become unsteady on your feet.
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| Patient Demographics: |
| ***Forename:*** | Click here to enter text. | ***Gender:*** | Select option. |
| ***Surname:*** | Click here to enter text. | ***Date of Birth:*** | DD | Month | Year |
| ***Patients******Address:*** | Click here to enter text. | ***Email Address:*** | If known.  |
| ***Postcode:*** | Click here to enter text. |
| ***Contact Tel N°:*** | Click here to enter text. | ***NHS N°*** | If known.  |
| ***GP Practice******Name:*** | Click here to enter text. | ***GP Surgery Address:*** | Click here to enter text. |
| ***Are you pregnant?*** | Choose an item. | ***If yes, please state how many weeks pregnant*** | Gestation. | Weeks |
| ***Do you have any special requirements?*** (i.e. Interpreter/BSL) | Choose an item. | ***If yes to special requirements, please supply further information:*** Click to add details.  |
| *Please continue with questions on page 2* |

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| Referral Details: |
| Please describe your current problem and symptoms below (including location of pain, swelling, stiffness, pins and needles, weakness etc). |
| Click here to enter text. |
| Is your pain there all of the time? | Choose an item. | Do you wake up at night because of pain? | Choose an item. |
| How long have you had this problem? | Choose an item. | Is your problem getting | Choose an item. |
| Have you had an X-Ray or any other tests for this problem?  | Choose an item. |
| If yes to the above please give details  | Click here to enter text. |
| Have you had Physiotherapy or other treatment for this problem?  | Choose an item. |
| If yes to the above, please give details including approximate dates: | Click here to enter text. |
| Is this problem causing you to be absent from work? | Choose an item. |
| Are your day to day activities affected by your pain?  | Choose an item. |
| NB: if this referral is for back pain the following questions must be answered or referral will be rejected: |
| Is this referral for **back pain?** | Choose an item. |
| If yes to the above, please complete **STarTback** questions (Q1-Q9) below: | Yes | No |
| 1 | My back pain has **spread down my leg(s)** at some time in the last two weeks |[ ] [ ]
| 2 | I have had pain in the **shoulder** or **neck** at some time in the last two weeks |[ ] [ ]
| 3 | I have only **walked short distances** because of my back pain |[ ] [ ]
| 4 | In the last two 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 two weeks?** |
| Not at all | Slightly | Moderately | Very much | Extremely |
|[ ] [ ] [ ] [ ] [ ]
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| It is recommended that you keep this sheet for your informationUnfortunately, this form is currently unable to be completed on a mobile device. |
| What Next?* Complete your self-referral form FULLY
* Incomplete forms WILL NOT be processed and this will delay your assessment

1* Return self referral form either by post, email or in person
* Southampton residents – SNHS.MSKSPAreferrals@nhs.net
* Portsmouth residents – SNHS.MSK-Physiotherapy-Referrals-Portsmouth@nhs.net

2* Southampton residents – Southamptonemail@address.com Portsmouth residents – Portsmouthemail@address.com
* Please allow 4 clear working days from submitting your referral form before you contact the department. (Posted referrals will take longer).

3For Southampton referrals contact0300 300 2012 – Option 2Mon-Fri 0800-1600For Portsmouth referrals contact02392 680057 Mon-Fri 0800-1600 |
|  Southampton or PortsmouthFor Portsmouth appointments post to:St Mary’s Community Hospital CampusMilton RoadPortsmouthHantsPO3 6ADFor Southampton appointments post to:Adelaide Health CentreWestern Community Hospital Campus William Macleod WaySouthamptonHantsSO16 4XE |
| * Self Referrals can only be accepted from patients age 16 and over.
* If you do NOT contact the department within 2 weeks your referral will be discharged.
* Please be aware, we cannot be held responsible for the security of your email and its contents during transit.  We can however, reassure you that once we have received the email we will store the information in a confidential, appropriate manner.
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