

## Eastern Cheshire MSK Physiotherapy Clinical Triage and Assessment Service

### SELF REFERRAL FORM

(Please ensure all fields are completed in black ink/typed and legible or the referral may be rejected)

#### IMPORTANT PLEASE READ

**Please do not complete this form if you have any of the following symptoms’.**

- Changes in your bladder and bowel habits
- A hot swollen joint
- Constant severe pain and you are unable to find relief
- Weakness, pins and needles, loss of feeling
- Unexpected weight loss

**Please note, the service is NOT permitted to see:**

- Patients who require emergency treatment (immediate, serious and life threatening)
- Patients in their own homes that do not meet the criteria for domiciliary care (i.e. are housebound whether this short term post op or long term)
- Patients, requiring joint injections as part of palliative care
- Patients post amputation (if specialist equipment not available)
- Patients who have undergone extensive, complicated surgery, as defined by the operating consultant for an orthopaedic or rheumatological condition which requires specialist intervention
- Patients requiring specialist intervention for women’s health problems (except symphysis pubis dysfunction)

**If any of the above apply to you, please make an appointment to see your GP instead of self-referring to the triage service**

<b>Full name (Inc. Mr / Mrs / Miss / Ms)</b>			<b>NHS Number</b>		
<b>Address</b>			<b>Date of Birth</b>		
			<b>Today’s Date</b>		
			<b>Best Contact No.</b>		
<b>Postcode</b>			<b>Email Address</b>		
<b>Are you a Forces Veteran?</b>	Yes/No	<b>Do you require an interpreter?</b>	Yes/No	<b>Do you require patient transportation services?</b>	Yes/No
<b>Which GP practice are you registered at?</b>					
<b>Please describe your main problem including body part and symptoms? (E.g. left knee pain &amp; stiffness, pins and needles, numbness etc.)</b>					
<b>Please answer the following questions by placing a tick (✓) in the appropriate box:</b>					
<b>How long have you had this problem?</b>			Less than 1 month		<input type="checkbox"/>
			1-6 months		<input type="checkbox"/>
			6+ months		<input type="checkbox"/>

Is this problem...?	New <input type="checkbox"/>
	Reoccurrence of a previous problem <input type="checkbox"/>
	On-going long term problem <input type="checkbox"/>
Is your problem...?	Getting better <input type="checkbox"/>
	Staying the same <input type="checkbox"/>
	Getting worse <input type="checkbox"/>
Are you off work because of this problem?	Yes (please state how long have you been off work for)?
	No <input type="checkbox"/>
	Not applicable <input type="checkbox"/>
Have you had any previous Physiotherapy for this problem?	Yes (please state where and how long ago)?
	No <input type="checkbox"/>
	Not applicable <input type="checkbox"/>
Have you had or are you awaiting any investigations for this problem?	Yes please state what you had, when and any known results?
	No <input type="checkbox"/>
Have you seen your GP, Consultant, Occupational health or another healthcare professional e.g. practice nurse about this problem?	Yes (please state who and when)?
	No <input type="checkbox"/>

To ensure that we prioritise and direct your referral to the correct service quickly and appropriately, we may need to access a medical health summary and current medication list from your GP records.

The information accessed will remain confidential at all times.

If you **DO NOT** give consent for this to take place please tick this box  and complete the below table.

Medical Conditions		Medication	
Signature		Date	

Please send the completed form to InHealth:

E-mail: [INL.generalenquiry-nwcats@nhs.net](mailto:INL.generalenquiry-nwcats@nhs.net) / Fax: 0333 321 1954 or Post to: InHealth Limited, Eastern Cheshire MSK Triage Service, Patient Referral Centre, Sandbrook House, Sandbrook Way, Rochdale, Greater Manchester, OL11 1RY