Self-Referral to Musculoskeletal Physiotherapy

Self-referral Physiotherapy is available for adults over 16 who are suffering from low back pain, neck pain, or recent injuries such as strains and sprains, or joint and muscular pain. **For all other conditions you should consult your GP.**

First Name:*

Today's Date:*

Last Name:*

Date of Birth:*

Health and Care Number:
(*if known*):

Your GP's Name:*

Address:*

Postcode:

Your GP Surgery: *

E-mail:

Telephone numbers (please tick)
We may contact you for additional information
Indicate telephone number and time (Monday – Friday) most suitable

Home: _____ ☐

Work: _____ ☐

Mobile: _____ ☐

10am - 12pm ☐ 2pm - 4pm ☐ Other ☐ _____

Do you require an interpreter?* Yes ☐ No ☐

If yes, which language? _____

Do you require adjustment for reasons related to a disability?*

Yes ☐ No ☐ **If Yes, please give details:** _____

_____

_____

How long have you had this problem? (Please tick) *

1 - 6 Days ☐ 1 - 4 Weeks ☐
1 - 11 Months ☐ >1 Year ☐

Have you been to see your GP and/or your Consultant about this problem? *

Yes ☐ No ☐

Has your doctor suggested you self-refer to Physiotherapy? *

Yes ☐ No ☐

Have been to see a Physiotherapist about this problem?*

Yes ☐ No ☐

Is the problem?*

New ☐
Return of an old problem ☐

Are your symptoms getting worse?*

Yes ☐ No ☐

Are you able to carry out your normal activities? *

Yes ☐ No ☐

Are you off work because of this problem? *

Yes ☐ No ☐ Not applicable ☐

If Yes, how long?

1-3 days ☐ Up to 7 days ☐
8 days or more ☐

Are you unable to care for a dependant because of this problem?*

Yes ☐ No ☐ Not applicable ☐

Where is your problem? (Please tick all that apply) *

Back ☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Chest ☐ Hip ☐ Knee ☐ Leg ☐

Do you know what caused your problem? *

Yes ☐ No ☐ **If yes please give details:** _____

_____

_____

_____

Have you had any unexpected recent weight loss?*

Yes ☐ No ☐ **If yes please give details:** _____

_____

_____

_____

If you have back pain, do you also have leg pain? * Yes ☐ No ☐

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

Do you have any other symptoms, such as numbness, tingling or muscle weakness? Yes ☐ No ☐

If yes please give details: _____

_____

Please tick where you wish to attend for assessment: *

Ards Community Hospital ☐ Bangor Community Hospital ☐ Downe Hospital ☐

Lagan Valley Hospital ☐ Lisburn Health Centre ☐ Stewartstown Road Clinic ☐ Saintfield ☐

I agree that the information that I have provided in this form is accurate. *

Signature: _____

Please ensure all fields marked with * are completed or we will be unable to process the referral. On completion please return to:

Central Booking Office, 1st Floor, Main Building, Downshire Hospital, Ardglass Road, Downpatrick, Co. Down, BT30 6RL