

**PLEASE NOTE : THIS IS NOT
A GP/CLINICIAN REFERRAL FORM**



Self-referral to Circle Bedfordshire MSK Service

You can refer yourself to the Circle Bedfordshire MSK Service for help with your bone, muscle or joint problem if you meet the following criteria:

- You are aged 18 or over
- You have had your bone, muscle or joint problem for less than six months
- You are registered with a Bedfordshire GP surgery
- Your problem is in a **single** (one) joint or area

Please complete this form to give us as much information as possible about your condition.

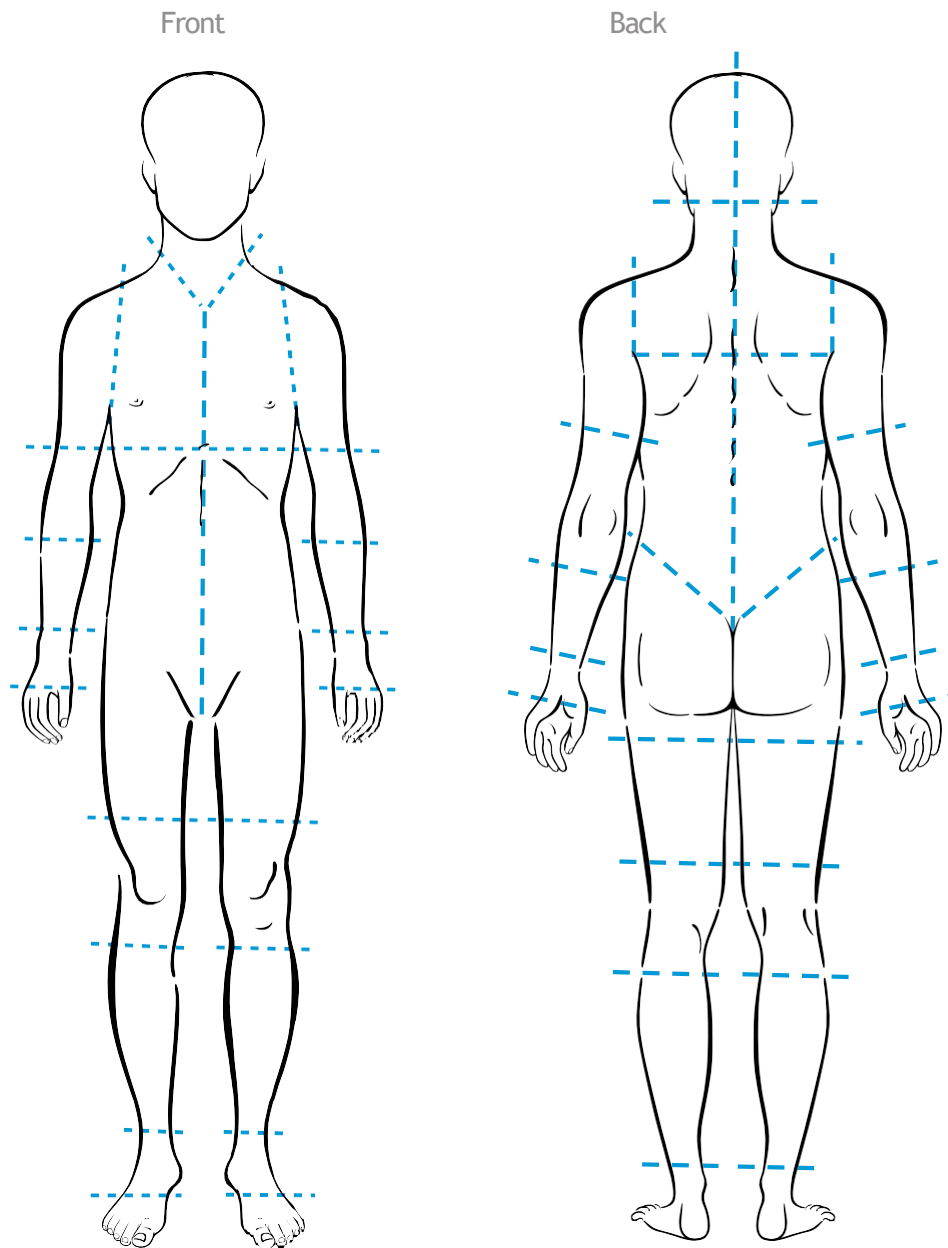
In some cases, you may need to see your GP for further assessment before you can be referred to our MSK service.

If you are completing this form by hand, please use block capitals.

* Denotes a mandatory field: referrals may be rejected if not fully completed.

Date	<input type="text"/>		
*Name	<input type="text"/>		
*Date of birth	<input type="text"/>	*Gender	<input type="text"/>
*Address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		
*Postcode	<input type="text"/>		
*Telephone	<input type="text"/>		
*Email	<input type="text"/>		
*GP name	<input type="text"/>		
*GP surgery	<input type="text"/>		
Height (m)	<input type="text"/>	Weight (kg)	<input type="text"/>

Shade in the area where you experience your symptoms on the body chart.



Briefly describe your problem and why you need help from the MSK service (please note this must be for a single joint or area only).

Please answer the following questions about your current problem and how it affects you during a typical week.

Impact on daily function e.g. work, caring duties, self-care	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	N/A <input type="checkbox"/>
Impact on sleep	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	N/A <input type="checkbox"/>
Severity of pain (where 0 = no pain and 10 = worst pain imaginable)	1-4 <input type="checkbox"/>	5-7 <input type="checkbox"/>	8-10 <input type="checkbox"/>	N/A <input type="checkbox"/>
Please indicate how much pain relief medication you are currently taking for this problem	None <input type="checkbox"/>	Some <input type="checkbox"/>	Maximum daily dose <input type="checkbox"/>	
Please write the names of any pain medication you are currently taking:				
For how long have you had this problem?	Less than 6 weeks <input type="checkbox"/>	Between 6 weeks and 6 months <input type="checkbox"/>	Over 6 months <input type="checkbox"/>	
Did your problem start as a result of an injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are your symptoms getting worse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Do you have any other significant medical/health problems e.g. cancer, heart problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
If yes, please give details:				
Have you had physiotherapy for this problem before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
If yes, how long ago?				

If you answer yes to any of the questions below, please see your GP first.

If you have back pain, have you had any change in sensation between your legs (the "saddle" area), problems controlling your urine or bowels, or a change in sexual function?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A (not back pain) <input type="checkbox"/>
If yes, is this a new problem, rather than an existing issue?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, please provide further details:			
Have you suddenly lost weight without trying?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Have you had any symptoms such as numbness, tingling or muscle weakness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you require an interpreter?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, what language?			
Where did you get a copy of this self-referral form from?	Website <input type="checkbox"/>	GP <input type="checkbox"/>	Physio clinic <input type="checkbox"/>

Please return all forms to:

Email:
msk.bedfordshire@circlehealthgroup.co.uk

Post:
Circle Bedfordshire MSK Service
Lakeview House
Priory Business Park
Fraser Road
Bedford
MK44 3WH