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

Circle Integrated Care

Physio Line self-referral form

You can now self–refer to our Physio Line telephone service for muscle and joint problems if you meet the following criteria:

- You are aged 18 or over.
- You have had your condition for **less** than six months.
- Your GP is in the Greenwich CCG (if you are not sure please contact your GP surgery or visit their website).
- Your complaint is regarding a **single** (1) joint/area.

Please fully complete this form so we can gather as much information as possible regarding your condition.

In some cases, you may be required to see your GP for further assessment prior to being referred into the 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			
*Name			
*Date of birth		*Gender	
*Address			
*Postcode			
*Telephone			
*Email			
*GP name			
*GP surgery			
Height (m)		Weight (kg)	

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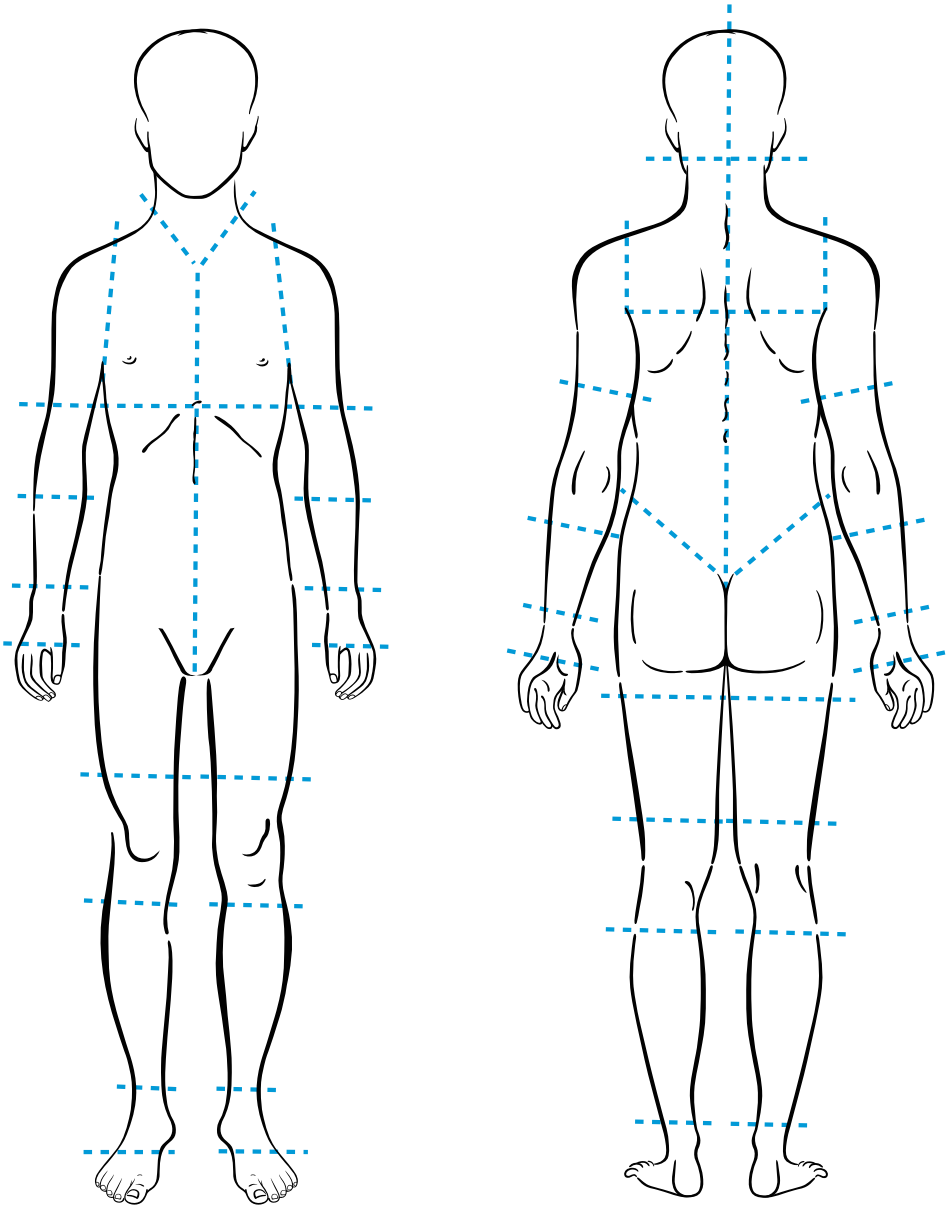
Click to shade in the area where you experience your symptoms on the body chart.



Please give a brief description of your problem and why you feel you need physiotherapy (please note this must be a single joint/area only).

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Please complete the following questions regarding your current problem and how it affects you, on average, over the course of a week.

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

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

If you have back pain, have you had any change in sensation between your legs (the Saddle area), problems controlling your urine, bowels or change in sexual function?	Yes ☐	No ☐	Not Applicable [Not back pain] ☐
If you have back pain, have you had any difficulties controlling your urine?	Yes ☐	No ☐	
If yes, is this a new problem, rather than an existing issue?	Yes ☐	No ☐	
If **yes**, please provide further details			
Have you suddenly lost weight without trying?	Yes ☐	No ☐	
Have you had any symptoms such as numbness, tingling or muscle weakness?	Yes ☐	No ☐	
Do you require an interpreter?	Yes ☐	No ☐	
If **yes**, what language?			
Where did you get a copy of this self-referral form?	GP ☐	Physio clinic ☐	Website ☐
Other (please specify)			

Please return all forms to

Email:
msk.greenwich@circlehealthgroup.co.uk

Post:
Circle Integrated Care
Eltham Community Hospital
30 Passey Place
London
SE9 5DQ
NB: THIS IS A MAILING ADDRESS ONLY