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

Circle Integrated Care

Self-referral to Circle Greenwich MSK Service

You can refer yourself to the Circle Greenwich 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 Greenwich 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.

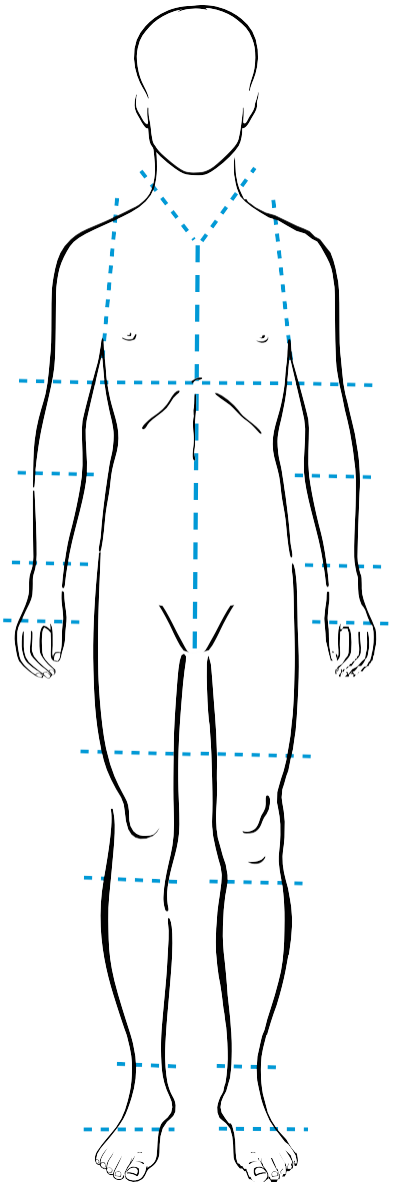
If you are completing this form by hand, please use block capitals.

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

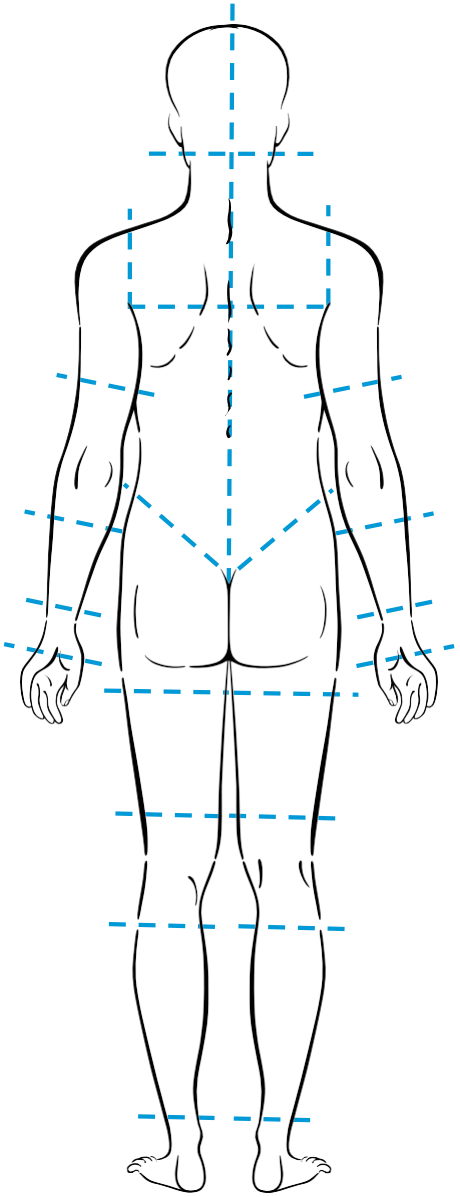
Date			
*Name			
*Date of birth		*Gender	
*Address			
*Postcode			
*Telephone			
*Email			
*GP name			
*GP surgery			
Height (m)		Weight (kg)	

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

Front



Back



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 ☐	Moderate ☐	Severe ☐	N/A ☐
Impact on sleep	Mild ☐	Moderate ☐	Severe ☐	N/A ☐
Severity of pain (where 0 = no pain and 10 = worst pain imaginable)	1-4 ☐	5-7 ☐	8-10 ☐	N/A ☐
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 pain medication you are currently taking:				
For 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 getting worse?	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 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 ☐	No ☐	N/A (not back pain) ☐
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 from?	Website ☐	GP ☐	Physio clinic ☐

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