Self Referral to Physiotherapy

Cumbria Partnership NHS
NHS Foundation Trust

Please complete **all sections** of this form and return it to your GP reception desk ensuring that your name, full address and date of birth are on the top. **Please note – incomplete forms may not be processed.**

First Name **Surname**
(please put full name and not just initials)

Address (Including postcode)

Date of Birth / / **Date of Referral / /**

Phone Number (Home) OK to leave message Yes ☐ No ☐
Phone Number (Mobile) OK to leave message Yes ☐ No ☐
Phone Number (Work) OK to leave message Yes ☐ No ☐

GP Name and Practice –

1. Please give a brief description of why you need a physiotherapy assessment (include area of body affected)

_____

_____

2. How long have you had this problem? _____

3. Has this problem previously been treated with physiotherapy Yes ☐ No ☐

4. Are the symptoms worsening? Yes ☐ No ☐
(If yes, please give details)

5. Are you able to carry out normal activities? Yes ☐ No ☐

6. Are you off work/unable to care for a dependent because of this problem Yes ☐ No ☐ Not applicable ☐

7. Please give details of any other treatment you have received for these symptoms _____

_____

_____

8. Have you had any sudden weight loss without trying? Yes ☐ No ☐

9. Have you had any other symptoms such as numbness, tingling or muscle weakness? Yes ☐ No ☐
(If yes please give details)

10. If you have back and leg pain, have you developed problems with your bladder or bowel? Yes ☐ No ☐ Not applicable ☐

11. Please list any current or past medical conditions i.*e. heart conditions, high blood pressure, arthritis etc* _____

_____

_____

12. Please list any medications your are currently taking _____

_____

_____