Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Physiotherapy Self Referral Form

Please fill out ALL 3 pages of this form and ensure you use BLOCK CAPITALS in BLACK PEN only.

This service is not yet available to children under 16 or for neurological, respiratory, obstetric and gynaecological problems.

Full Name:	
Address: Post Code:	
Date of Birth:	Contact Telephone Numbers Home Tel: Work Tel: Mobile:
GP Name: Practice:	

Which area of your body is affected? (e.g. back/knee/shoulder)
Please give a brief description of your symptoms and why you think it started (E.g. pain/swelling/stiffness).
How long have you had the problem? ……Days ……Weeks ……Months ……Years
Is this problem New ☐ Flare up of old problem ☐ Ongoing long term problem ☐
Is your problem Getting better ☐ Getting worse ☐ Staying the same ☐
Are you off work or unable to care for a dependent because of this problem? Yes ☐ No ☐ (If yes, please give details)
Please list **All** of the medication you are taking
What would be a good result from Physiotherapy for you?
Have you been to Physiotherapy for this before? Yes ☐, when? No ☐

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Since the onset of this problem has there been any sudden change to…		
Bladder problems – Difficulty in passing water, feeling that you cannot empty your bladder or losing control of the bladder (wetting yourself)	Yes ☐	No ☐
Bowel problems – a loss of bowel control (soiling yourself)	☐	☐
Have you lost weight recently for reasons you cannot explain?	☐	☐

If you have ticked **YES** to any of the three symptoms above, and you **HAVE NOT** seen a doctor for this symptom, it is essential that you arrange an **URGENT** appointment with your **GP** or call **NHS Direct** (0845 46 47) or attend your local **A&E Department**

DO NOT SEND IN THIS FORM UNTIL YOU HAVE SOUGHT FURTHER ADVICE

Tick the box to confirm you have sought further advice ☐

Since the onset of this problem, do any of the following apply to you?		
	Yes	No
Severe pain at night that wakes you	☐	☐
Double vision	☐	☐
Problems swallowing	☐	☐
Does coughing or sneezing change your symptoms	☐	☐
Tinnitus (Ringing in ears)	☐	☐
Nausea	☐	☐
Headache	☐	☐
Facial Pain	☐	☐
New problems with speaking (e.g. slurring)	☐	☐
New problems with walking	☐	☐
Pins and needles anywhere	☐	☐
Numbness anywhere	☐	☐
Dizziness	☐	☐

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General Health Please complete all questions with a tick in the appropriate box							
	Yes	No		Yes	No		Yes	No
Rheumatoid arthritis	☐	☐	History of cancer	☐	☐	Diabetes	☐	☐
High blood pressure	☐	☐	Thyroid Problems	☐	☐	Heart problems	☐	☐
Low blood pressure	☐	☐	Major Surgery	☐	☐	Pacemaker	☐	☐
				Please add details including date of surgery.				
Lung / Breathing problems	☐	☐	Osteoporosis	☐	☐	Epilepsy	☐	☐
Broken bones	☐	☐	Are you pregnant	☐	☐	Allergies	☐	☐
If you have answered YES to any of the above or have any other medical problems, please provide further details here:								
Did your GP suggest you contact the service? Yes ☐ No ☐								

Patient signature: Date:

Please return this form to:

Physiotherapy Department, Withybush General Hospital, Fishguard Road, Haverfordwest, SA61 2PZ. Tel: 01437 77