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**Medway Community Healthcare**

**MSK Physiotherapy/Triage Referral Form – self referral**

This referral form is for the Medway Community Healthcare MSK Triage service for patients with a Medway & Swale GP.

Physiotherapy is provided by a number of different providers who offer appointments across Medway and Swale. The aim of the triage service is to receive and screen all the referrals and direct to an appropriate physiotherapy or community orthopaedic service. Once your referral has been read and screened by a senior clinician we will be in touch to arrange an appointment/onward referral.

Please note we can only accept one referral for one body part. If you have pain in multiple areas you need to consult your GP.

Please note – this is not an emergency service and so if you have any serious issues please contact 111 or your GP.

Before completing the form, please carefully read the following information as this may affect whether you are able to submit your referral.

Since the onset of this problem do any of the following apply to you? If you have the symptom(s) please tick

* Unexplained Weight Loss and a history of cancer
* Fever or Night Sweats
* Unexplained Bladder or Bowel problems, particularly
* Loss of feeling/pins and needles between your inner thighs, genitals or back passage
* Increasing difficulty when you try to urinate
* Increasing difficulty when you try to stop or control your flow of urine
* Not knowing when your bladder is either full or empty
* Inability to stop a bowel movement or leaking
* A recent onset of pain in both legs with any of the above

(Consider an urgent appointment with your GP if symptoms are stable or attend your local A&E Department if these symptoms are new within the last few days or recently worsening. For further information follow this link:

<https://www.macpweb.org/Resources/37b9fa6e-1b59-43fc-a2a3-d0a8f8430720>)

* Unremitting/constant Night Pain
* A loss of coordination or strength in the arms or legs causing difficulty with walking or dextrous tasks like handwriting, texting or using zips and buttons.

If you have ticked any of these symptoms and you have not discussed them with a doctor, please arrange a review with your GP Practice. You will be unable to submit this form in the presence of these symptoms and a GP referral is needed. If any of the symptoms are new and severe, please consider attending A&E, if you are not sure, please call 111.

**Please provide the details below:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Who is completing this form? | * Patient * Patient Representative * MCH Staff with Patient * Healthcare Professional | | | | | | |
| NHS Number (if known) |  | |  | |  | |  |
| First Name |  | |  | |  | |  |
| Last Name |  | |  | |  | |  |
| Date of Birth |  | |  | |  | |  |
| Gender | * Male | * Female | | * Not Specified | | * Unknown | |
| Ethnicity |  | |  | |  | |  |
| Address Line 1 |  | |  | |  | |  |
| Address Line 2 |  | |  | |  | |  |
| Address Line 3 |  | |  | |  | |  |
| Postcode |  | |  | |  | |  |
| Email address |  | |  | |  | |  |
| Can we send your appointment details by email? | * Yes | * No | | | | | |
| Telephone No |  | |  | |  | |  |
| Mobile No |  | |  | |  | |  |
| Can we send your appointment details by text? | * Yes | * No | | | | | |
| GP Name |  | |  | |  | |  |
| GP Surgery |  | |  | |  | |  |
| Name of next of kin & relationship |  | |  | |  | |  |
| Next of kin contact details |  | |  | |  | |  |
| Interpreter required? | * Yes   Which language? | | * No | | | | |

|  |  |  |
| --- | --- | --- |
| Please give a detailed description of why you want a physio assessment |  | |
| Where is your pain? |  | |
| When did your pain start? |  | |
| Is the problem | * New * Ongoing | |
| Are the symptoms worsening? | * Yes | * No |
| Have you had any treatment – for example, medication, physiotherapy/osteopathy (when & how many sessions), injections, previous surgery? |  | |
| Are you off work because of the current symptoms? | * Yes | * No |
| What medication are you taking? |  | |
| General health: | | |
| * Epilepsy * Breathing conditions * Osteoporosis * History of cancer * Diabetes * High blood pressure * Heart problem * Under active thyroid | * Any operations in the past 10 years? * Injuries/accidents in the past 10 years? * Mental health issues * Rheumatoid issues such as Rheumatoid Arthritis, fibromyalgia, polymyalgia * Have you taken steroids in the past six months? * Are you taking warfarin or any anticoagulants? | |
| Any other medical condition and other comments? | | |
| Allergies |  | |
| What do you want to achieve from your physiotherapy? |  | |
| Any additional supporting information |  | |

**Please complete only if you require post-operative physiotherapy**

|  |  |  |
| --- | --- | --- |
| What surgery did you have? |  | |
| What was the date of surgery? |  | |
| In which hospital did you have the surgery? |  | |
| Do you have dressings or clips in situ? | * Yes | * No |
| If yes, when will the clips/stitches be removed? | **date** | |

**Please complete if requiring repeat steroid injection**

|  |  |
| --- | --- |
| When did you have your last injection? |  |
| Did it help? |  |
| Where (body part) did you have your injection? |  |
| Are you expecting another injection? |  |

**Please complete only if you have pelvic health related conditions**

The pelvic health physiotherapy team can help with problems that occur during pregnancy or after birth such as:

* pregnancy related Pelvic Girdle Pain (PPGP)
* lower back pain
* separation of tummy muscles (Diastasis Recti)
* hip pain
* rib pain

Problems at any stage in life:

* bladder and/or bowel problems such as leakage or difficulty controlling them
* pelvic organ prolapse
* pelvic pain

|  |  |  |
| --- | --- | --- |
| Please give a detailed description of why you want a physio assessment |  | |
| Have you had surgery? | * Yes | * No |
| Is surgery planned? | * Yes | * No |
| What was the date of surgery? |  |  |

Would you prefer your assessment/treatment to be carried out by a specific physiotherapy provider or in a specific area?

Please indicate when you would be available to attend appointments:

* Mornings
* Afternoons
* Evenings
* Weekends

|  |  |
| --- | --- |
| Comment |  |

Please send this completed form to [XXXXXXX](mailto:woundclinic.medway@nhs.net)

***For Healthcare Professionals completion only with any additional supporting information****:*

Free text