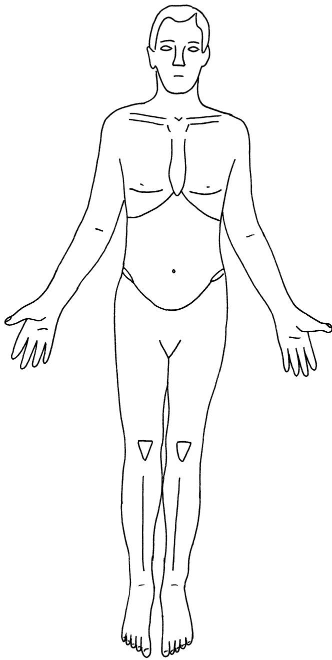
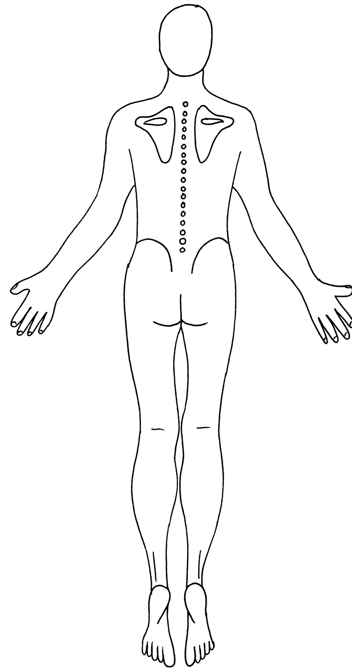
Medication	YES	NO
Steroids	☐	☐
Anticoagulants	☐	☐

Please list ALL the medication you are taking

Indicate on the pictures where you get your symptoms, for example pain, pins and needles, numbness





Please make sure you have filled in all parts of the form

Signature ______________________

Date ______________________

If you have any problems completing this form, please ring the number below.

Please return this form to:

Physiotherapy Department
Bronllys
Brecon
Powys
LD3 OLU
Tel: 01874 712455

Physiotherapy Service Self Referral Form

GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys | Powys Teaching Health Board

This form should only be used for patients wishing to have physiotherapy for musculoskeletal problems (back/neck pain, joint pain, soft tissue injuries)
If you are under the age of 16 or wish to have treatment for a lung or breathing problem, a neurological problem or an obstetric/gynaecological problem, please see your Health Practitioner

This form will be used to determine how your referral is processed. Please ensure you:

- **Use a BLACK Pen**
- **Use BLOCK CAPITALS**
- Complete ALL sections of the form

Incomplete forms will be returned to you which will cause a delay in the management of your problem. Once received, the form will be reviewed and placed on a waiting list.

Full Name

Address

Post Code

Date of Birth: ___/___/______.

GP Name ______________________

Practice ______________________

____

Your Contact Telephone Numbers

		Can we leave a message?
Home	______________	Yes / No
Work	______________	Yes / No
Mobile	______________	Yes / No

Please give a brief description of your symptoms, or why you wish to see a physiotherapist

How long have you had this problem? Days ___. Weeks ___. Months ___. Years ___.

How did it start? *(Just came on, injury, fall, long term problem etc)*

Are you in pain all the time or does it come and go?

Pain all the time ☐

Comes and goes ☐

How often do you have the pain? ______________

What makes the pain WORSE?

What makes the pain BETTER?

Is it generally worse? *Tick answer that applies most*

In the morning ☐ In the afternoon ☐ In the evening ☐ At night ☐ No pattern ☐

Have you had treatment / physiotherapy for this condition in the past? **Yes / No**
(if YES, please give details)

Have you had any X-rays or other tests? **Yes / No** *(if YES, please give details/ results)*

Have you had this problem before? **Yes / No** *(if YES, please give details)*

If this is a problem with your joints:

Does your joint?		YES	NO
	Give Way		
	Click		
	Lock		
	Swell		

Are you off work or unable to care for a dependant because of this problem? **Yes / No**
(if yes, please give details)

Please indicate any activities you are unable to do because of this problem

What are your expectations from Physiotherapy?

SINCE THE ONSET OF THIS PROBLEM Do any of the following apply to you? If you have the symptoms please tick YES If you do not have the symptoms please tick NO

	YES	NO
Bladder Problems—a difficulty in passing water or feeling you cannot empty your bladder		
Bowel problems—a loss of bowel control (soiling yourself)		
Unexplained weight loss		

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

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

General Health	YES	NO		YES	NO
Rheumatoid Arthritis			History of Cancer		
High Blood Pressure			Thyroid Problems		
Low Blood Pressure			Major Surgery		
Fractures / Broken Bones			Osteoporosis		
			Diabetes		
Heart Problems			Pacemaker		
			Epilepsy		
Allergies			Lung / Breathing Problems		
Are you pregnant					

If you have answered YES to any of the above or have any other medical problems, please provide further details here: