**Self-Referral - West Cumbria Physiotherapy Service**

**Please complete ALL SECTIONS of this form** and return it to your GP reception desk or to your preferred Physiotherapy Department.

Please ensure that your full name, full address and date of birth are completed.

**Please note - incomplete forms may not be processed**

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| **PATIENT DETAILS:** |
| Full Name:  | GP Name: |
| Date of Birth:  | Name of Surgery:  |
| Today’s Date:  | Practice code:  |
| Your Address: | Your Occupation: |
| Phone Numbers: Home -  | OK to leave message (incl. SMS text)? Yes  No  |
| Mobile -  | OK to leave message (incl. SMS text)? Yes  No  |
| Work -  | OK to leave message (incl. SMS text)? Yes  No  |
| **CONSENT:**Consent given for the information within this referral to be sent to the receiving care team Consent given for the receiving care team to access the summary / full GP record (where available) for the duration of the period of care, where there is a legitimate reason to do so |
| **INFORMATION NEEDS (provide further details below, where applicable):** |
| **Required:** Longer appointment  Language translation service Hearing loop facility area British sign language interpreter |  Easy read documents / information leaflets  Braille documents / leaflets Large print documents Note-taker | **Attending:**  Carer / relative Note-taker |

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| **PREFERRED CLINIC LOCATION(S):** |
| Copeland: |  West Cumberland Hospital, Whitehaven  Egremont  Cleator Moor  Seascale |
| Allerdale: |  Workington  Cockermouth  Maryport  Keswick  Wigton |

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| **REFERRAL DETAILS:** |
| 1. Please give a brief description of why you need a physiotherapy assessment (include area of the body affected):
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| 1. How long have you had this problem?
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| 1. Are the symptoms worsening? Yes  No

*If yes, please give details:*  |
| 1. Are you able to carry out normal activities? Yes  No
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| 1. Are you off work / unable to care for a dependant because of this problem? Yes  No  N/A
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| 1. Please give details of any other treatment you have received for these symptoms, including previous physiotherapy:
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| 1. Have you had any sudden weight loss without trying? Yes  No
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| 1. Have you had any other symptoms such as numbness, tingling or muscle weakness? Yes  No

*If yes, please give details:*   |
| 1. Have you had any recent changes to your bladder and bowel habits or altered sensation in the genital/saddle area? (*If yes, please see the back page for advice and guidance)* Yes  No  N/A
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| 1. Please list any current or past health issues or operations *i.e. heart conditions, high blood pressure, arthritis, etc.*
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| 1. Please bring a list of your current medications to your first appointment.
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