**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): |
| 1. How long have you had this problem? |
| 1. Are the symptoms worsening? Yes  No   *If yes, please give details:* |
| 1. Are you able to carry out normal activities? Yes  No |
| 1. Are you off work / unable to care for a dependant because of this problem? Yes  No  N/A |
| 1. Please give details of any other treatment you have received for these symptoms, including previous physiotherapy: |
| 1. Have you had any sudden weight loss without trying? Yes  No |
| 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 |
| 1. Please list any current or past health issues or operations *i.e. heart conditions, high blood pressure, arthritis, etc.* |
| 1. Please bring a list of your current medications to your first appointment. |