Please complete **both** sides of this form before your Physiotherapy Assessment.

To return your referral form to the physiotherapy department of your choice, please refer to the list of contact details on page three of this referral form.

|  |  |  |  |
| --- | --- | --- | --- |
| **Mr/Mrs/Miss/Ms/Dr/Other** | **Full Name:** | **Date of birth:** | **Gender:** |
| Full Address:……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………...  Telephone Numbers: Home:…………………………………….Mobile:……………………………………………..  Next of Kin…………………………………………… Relationship to you…………………………………………….  Contact Number:……………………………………………………………………………………………………….. GP Name/Practice………………………………………………………………………………………………………. NHS Number:………………………………………………………Ethnicity:…………………………………………. Who recommended that you have Physiotherapy: GP □ Consultant □ Self □ Other □Do you work for CFT □ RCHT □ If so, how did you hear about this service? |
| **Briefly describe your current problem, e.g. *knee pain, fractured ankle*** *(please note exceptions: 1. If you have a back or neck problem please see your GP who may refer you. 2. Patients under 16 years of age must be referred by a GP).* |
| **When did it start and how long have you had the symptoms?** |
| **How did it start?** |
| **Is your problem: Getting better □ Getting worse □ Staying the same □** |
| Using a scale of 0-10, score your level of pain, where 0 is no pain and 10 is the worst possible pain**0 1 2 3 4 5 6 7 8 9 10** |
| **Have you had any previous treatment for this problem?** *(e.g. medical treatment, physiotherapy, osteopathy, chiropractor):* □ YES □ NOIf yes, please give details, including WHERE and WHEN: |
| **Have you had any investigations for this problem?** *(e.g. scans, X-rays, blood tests)* □ YES □ NO*If yes, please give details:* |

**Updated February 2020**

 Physiotherapist Signature……………………….Name……………………..………Date & Time…………….……….. 1

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| **Name:** | **NHS Number:** | **Date of birth:** |
| **Your general health** – please tick if you have any of the following:

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|  | **YES** | **NO** |  | **YES** | **NO** |
| Any major illness/health problem |  |  | Unexplained weight loss |  |  |
| History of cancer |  |  | Rheumatoid Arthritis |  |  |
| Diabetes |  |  | Epilepsy |  |  |
| Heart problems |  |  | Pregnancy (current) |  |  |
| Blood pressure problems |  |  | Any surgery/operations |  |  |
| Chest/breathing problems |  |  | Previous fractures |  |  |
| Steroids |  |  | Osteoporosis |  |  |
| Anticoagulants |  |  | Any other joint problems |  |  |
| Any bladder/bowel symptoms |  |  | Allergies |  |  |

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***Please give details:***

|  |  |
| --- | --- |
| ***Please record your height*** |  |
| ***Please record your weight*** |  |

 |
| **Please list any medications that you are taking or bring a print out of your current prescription:** |
| **What is your occupation?:** | **Please give details of any hobbies:** |
| **Are you:** Off sick due to this problemSelf-employed | □□ | EmployedUnemployed | □□ | RetiredStudent | □□ | Main carerOther | □□ |
| **What do you think is causing this pain and how do you think that Physiotherapy will be able to help you?** |
| **I confirm that the information provided above is correct to the best of my****knowledge. I give my consent to the physiotherapy assessment and treatment of my problem.** *(This may be withdrawn at any time during this period).***I am aware that I may be accompanied by a chaperone. I am aware that I can ask for a copy of my letter****I give consent for a message to be left on my answerphone Yes/No****Patient signature**…………………………………………………….**Date**………………….…………………………Are you completing this form on behalf of someone? Yes/No If so please state your name and relationship to this patientName…………………………………………………….………… Relationship………………………………….. |

Occasionally we may contact GPs regarding self-referral to physiotherapy. If you prefer that we do not contact your GP about this referral, please tick here.

Physiotherapist Signature……………………….Name……………………..………Date & Time 2



**Outpatient Physiotherapy Departments**

|  |  |  |
| --- | --- | --- |
| **Hospital** | **Telephone** | **Email** |
| **Helston Hospital** Meneage Road HelstonTR13 8DR | **01326 430224** | cpn-tr.helstonphysiotherapy@nhs.net |
| **Camborne Redruth Community Hospital**Barncoose Terrace RedruthTR15 3ER | **01209 318085** | cpn-tr.crchphysiotherapy@nhs.net |
| **Falmouth Hospital** Trescobeas Road FalmouthTR11 2JA | **01326 430020** | cpn-tr.falmouthphysiotherapy@nhs.net |
| **Newquay Hospital** St Thomas Road NewquayTR7 1RQ | **01637 834877** | cpn-tr.newquayphysiotherapy@nhs.net |
| **St Austell Community Hospital**Porthpean Road St AustellPL26 6AA | **01726 873077** | cpn-tr.sachphysiotherapy@nhs.net |
| **Bodmin Hospital** Boundary Road BodminPL31 2QT | **01208 251573** | cpn-tr.bodminphysiotherapy@nhs.net |
| **Liskeard Community Hospital**Clemo RoadLiskeard PL14 3XA | **01579 373560** | cpn-tr.liskeardphysiotherapy@nhs.net |
| **Launceston Hospital** Link Road LauncestonPL15 9JD | **01566 761022** | cpn-tr.launcestonphysiotherapy@nhs.net |
| **Stratton Hospital** Hospital Road StrattonBude EX23 9BP | **01288 320115** | cpn-tr.stratton-physiotherapy@nhs.net |
| **St Barnabas Hospital** 15 Higher Port View SaltashPL12 4BU | **01752 679025** | cpn-tr.saltashphysiotherapy@nhs.net |
| **Pentorr Health Centre** Trevol Business Park Trevol RoadTorpoint PL11 2TB | **01752 812406** | cpn-tr.torpointphysiotherapy@nhs.net |

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