

DEPT USE ONLY

Urgent / Routine

GP Direct Access Physiotherapy Service  
Tel: 020 3316 1111 Fax: 0844 774 6419  
Email: arti.centralbooking@nhs.net



Patient Self Referral to Physiotherapy

Date of Referral:

Once completed this form can be:

Emailed: [arti.centralbooking@nhs.net](mailto:arti.centralbooking@nhs.net)

Posted: The Central Referral Management Team – 338-346 Goswell Road London EC1V 7LQ

Handed In To: The Physiotherapy Reception at St Ann's Hospital, St Ann's Road, London, N15 3TH

Bounds Green Health Centre, 1a Gordon Road, London, N11 2PF

Lordship Lane Health Centre, 239 Lordship Lane, London, N17 6AA

Hornsey Central Neighbourhood Health Centre, 151 Park Road, London, N8 8JD

Whittington Hospital, Highgate Hill, London, N19 5NF

Holloway Community Health Centre, 11 Hornsey Street, London N7 8GG

Finsbury Health Centre, 17 Pine Street, London EC1R 0LP

PATIENT DETAILS:				
Surname:	First name:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth:
Address:			Post code:	
Daytime Tel No:		NHS No:		
Mobile No:		Hospital No:		
Is an interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, what language:		
Optional for data monitoring purposes only: how would you describe your ethnic origin?		Telephone No :		
Next of kin:		Contact Address:		

GP'S DETAILS	
Name:	Have you consulted your GP about this problem? Yes <input type="checkbox"/> No <input type="checkbox"/>
Practice: Mitchison Road Surgery 2 Mitchison Road N1 3NG	If Yes, what did they recommend:
Tel No: 020 7226 6016 (not after 1:30pm Thursdays) Fax: 020 7359 0043	

Give a brief description of your problem including how it started:
Area of pain / How it started / Any pins & needles or numbness – if so, where?

How long have you had this problem?			
Less than 2 weeks <input type="checkbox"/>	2 – 6 weeks <input type="checkbox"/>	More than 6 weeks <input type="checkbox"/>	More than 1 year <input type="checkbox"/>

Is the problem:		
New <input type="checkbox"/>	Flare-up of old problem <input type="checkbox"/>	Ongoing long-term problem <input type="checkbox"/>

Is your problem:		
Getting better	Getting worse	Staying the same

Have you had any investigations for this problem? (E.g. Scans, X-rays, Blood tests)

Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, please give details:	

<b>Have you had any previous treatment for this problem? (E.g. Medical treatment, Physiotherapy, Osteopathy, Chiropractic treatment)</b>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, please give details:	

Name:	Date of Birth:
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<b>General Health - Please tick if you have any of the following:</b>			
Lung problems	<input type="checkbox"/>	Any Major Illness	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	Current or Past Pregnancy	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Previous Fractures	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<i>Unexplained</i> Weight Loss	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	History of Cancer	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Fever or Night Sweats	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<i>Unexplained</i> Bladder or Bowel problems	<input type="checkbox"/>
Surgery / Operations	<input type="checkbox"/>	Night Pain	<input type="checkbox"/>
Poor General Health	<input type="checkbox"/>	Unsteady on feet	<input type="checkbox"/>
If Yes to any, please give details:			

<b>Please list any Medicine you are taking:</b>

<b>Employment status:</b>				
Employed <input type="checkbox"/>	Unemployed <input type="checkbox"/>	Retired <input type="checkbox"/>	Student <input type="checkbox"/>	Carer <input type="checkbox"/>
Please give details:				

<b>Any activities you do (E.g. Sports, Gym, Hobbies). Please give details:</b>

<b>Due to your current problem you are unable to:</b>			
Work <input type="checkbox"/>	Participate in activity/sport <input type="checkbox"/>	Care for dependent <input type="checkbox"/>	Other <input type="checkbox"/>
Please give details:			

<b>Your perception:</b>
<b>What do you think is happening to cause your problem?</b>

<b>What specific problems / difficulties would you like the physiotherapist to help you with?</b>
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<b>In what way do you feel the physiotherapist can help with these specific problems / difficulties?</b>