PHYSIOTHERAPY SELF REFERRAL FORM

For patients registered with a Cambridge GP

DynamicHealth Physiotherapy Department
Brookfields Hospital
351 Mill Road
Cambridge
CB1 3DF

If you are over 18 you can telephone the **Physio Direct Advice Line** on **0300 555 0210** Mon-Fri 1pm-5pm and speak to a senior physiotherapist who will assess you, give advice and may place you on the waiting list for an appointment if necessary **OR** you may fill out this form and return it to us at the above address or hand it in to your GP. You will be placed on a waiting list to be seen. Waiting times can vary based on demand.

If you are 16-17 years old you will be unable to use the telephone advice line but can access our service by filling in the form as above. We are unable to accept referrals for those **under the age of 16.**

Please note: the physiotherapy service does not provide emergency care. If you suspect you have sustained a serious injury/broken bone you should visit your nearest A&E department or telephone your surgery for further advice.

Full Name: _____ Date of Birth _____

Daytime phone no:_____ Mobile no: _____

Are you happy for us to leave an answer phone message? YES/ NO

Address: _____ GP ----------

_____ Surgery _____

_____

Postcode: _____ NHS Number:(if known)_____

Tick if you have hearing/ language difficulties preventing you from using the telephone service ☐

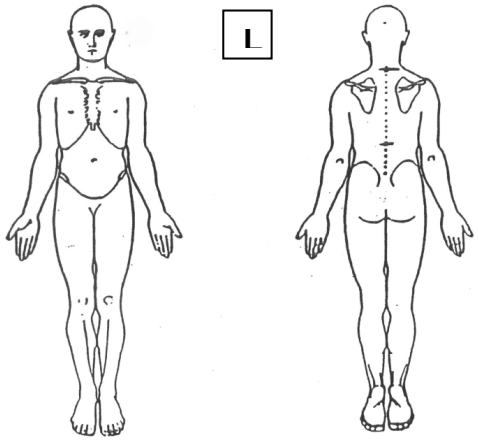
Please provide a brief description of your symptoms:

What type of symptoms are you getting? (Please circle)

PAIN ACHE WEAKNESS ABNORMAL SENSATION e.g. numbness, pins and needles tingling OTHER

Where does your problem trouble you?
Please indicate where you feel symptoms on the chart below

R L R



Please complete ALL questions

1 .Have you consulted your GP about this problem? YES ☐ NO ☐

2. Are you symptoms: IMPROVING WORSENING STAYING THE SAME

3. How long have you had the **current** problem? _____

4. Are you signed off sick **for this problem?** YES ☐ NO ☐

5. How long have you been off sick? _____

6. Have you attended physiotherapy before for this problem YES ☐ NO ☐

7. If so when? _____

8. Does your problem cause you significant sleep loss every night? YES ☐ NO ☐

9. If yes, how frequent and how long? _____

9. Do you have a personal history of cancer? YES ☐ NO ☐

10. Are you currently pregnant? YES ☐ NO ☐

Would you like your appointment to be at: *(Please indicate)*

Brookfields Hospital	
Sawston	
Your local GP surgery (if available)	

Addenbrookes Hospital	
Cambourne	

Signature: _____ **Date:** _____