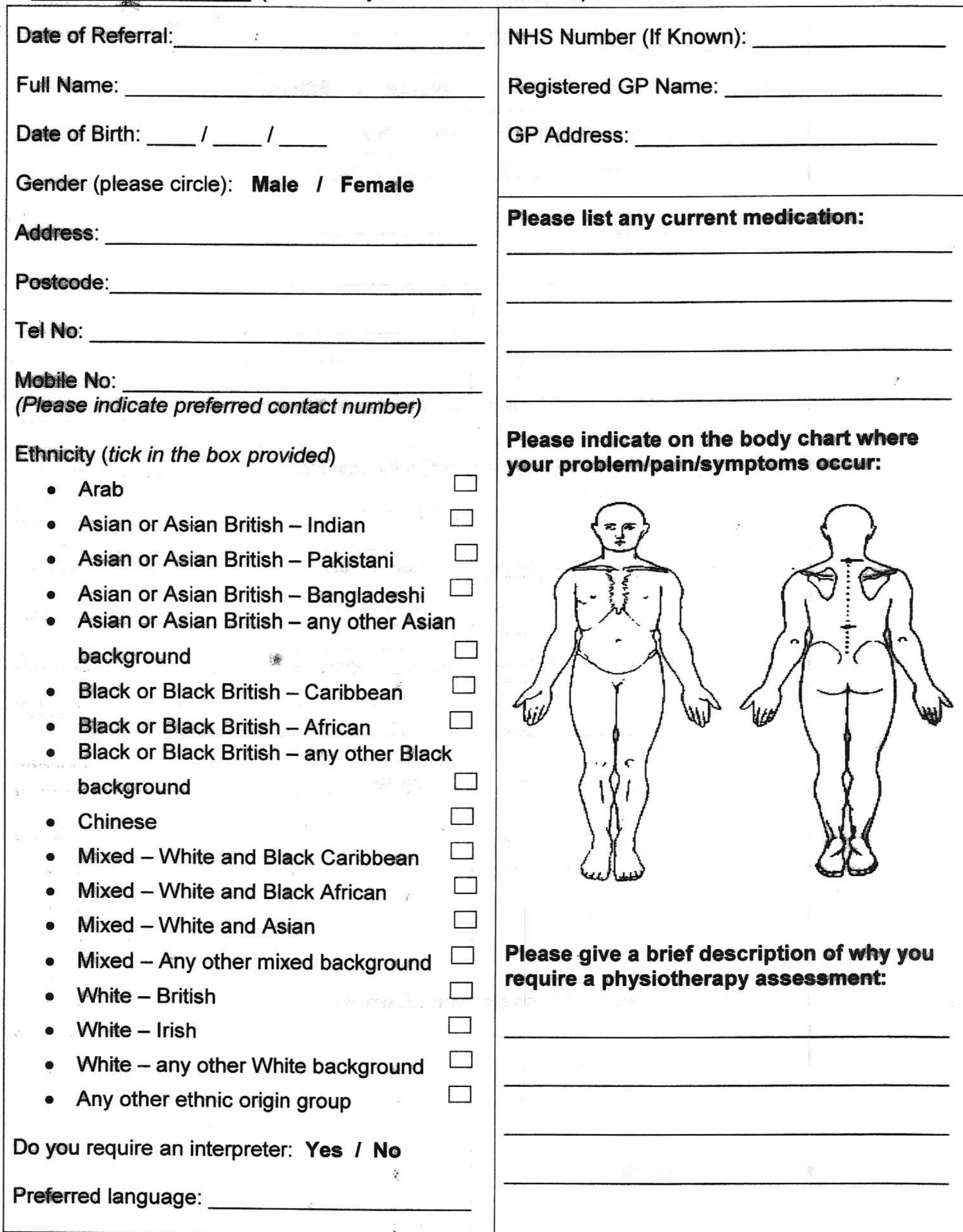
Birmingham Community Healthcare **NHS**

NHS Foundation Trust

Self-Referral Form (*Please only use this form if a telephone referral cannot be made*)



Date of Referral: ______________________

Full Name: ______________________

Date of Birth: ____ / ____ / ____

Gender (please circle): **Male / Female**

Address: ______________________

Postcode: ______________________

Tel No: ______________________

Mobile No: ______________________
(Please indicate preferred contact number)

Ethnicity (*tick in the box provided*)

- Arab ☐
- Asian or Asian British – Indian ☐
- Asian or Asian British – Pakistani ☐
- Asian or Asian British – Bangladeshi ☐
- Asian or Asian British – any other Asian background ☐
- Black or Black British – Caribbean ☐
- Black or Black British – African ☐
- Black or Black British – any other Black background ☐
- Chinese ☐
- Mixed – White and Black Caribbean ☐
- Mixed – White and Black African ☐
- Mixed – White and Asian ☐
- Mixed – Any other mixed background ☐
- White – British ☐
- White – Irish ☐
- White – any other White background ☐
- Any other ethnic origin group ☐

Do you require an interpreter: **Yes / No**

Preferred language: ______________________

NHS Number (If Known): ______________________

Registered GP Name: ______________________

GP Address: ______________________

Please list any current medication:

____

____

____

____

Please indicate on the body chart where your problem/pain/symptoms occur:

Please give a brief description of why you require a physiotherapy assessment:

____

____

____

____

Is this problem (please circle): **New / Ongoing**
How long have you had this problem?
Is this problem getting (please circle): **Better / Worse / Staying the same**
Have you seen your doctor about this problem? **Yes / No**
Have you previously had treatment for this problem? **Yes / No** *Please give details:*________________________________ ____ ____
Are you currently off work / unable to care for a dependent due to this complaint? **Yes / No**
If you have back pain or leg pain, have you had any difficulty passing or controlling urine? **Yes / No** (If 'Yes', please give details) ________________________
Have you had any sudden unexplained weight loss? **Yes / No** (If 'Yes', please give details) ______________________________
Have you had any other symptoms e.g. numbness, tingling, weakness? **Yes / No** (If 'Yes', please give details) ______________________________
For official use only Triaged by:____________________ Signature:__________________ Date triaged: ____________________

Please post the referral form to:

MSK Physiotherapy Referral Management Centre
1 Priestley Wharf
Holt Street
Birmingham
B7 4BN

Telephone 0121 466 6540