 

Physiotherapy Self-Referral

**Refer yourself directly to physiotherapy**

**The MSK Service is suitable for low back pain, neck pain, recent strains and sprains, joint and muscle pain.**

**Don’t use this form if:**

1. You are a patient under 16.
2. You are a Clinician.
3. You are being cared for by the Pain Service. If you are, contact the service directly on 0300 083 0000 option 1.

**If you experience any of the below, please see your GP before self-referring:**

1. Have recently become unsteady on your feet
2. Are feeling generally unwell or have a fever
3. Have any unexplained weight loss
4. Have a history of cancer

**Urgently Consult your GP or NHS 24 (by calling 111) if you have recently/ suddenly developed the following symptoms – DO NOT self-refer with these symptoms:**

1. Difficulty passing urine or controlling bladder/bowels
2. Numbness or tingling around your back passage or genitals
3. Numbness, pins and needles or weakness in both legs

**Please try the advice on our website:**

[MSK Together Partnership - Sherwood Forest Hospitals (sfh-tr.nhs.uk)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sfh-tr.nhs.uk%2Four-services%2Fmsk-together-partnership%2F&data=05%7C02%7Cjane.ferreira%40nhs.net%7Cc7e39b618ee44371283b08dca70900ae%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638568904631885228%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=eqYPsxH145Vs6ZNMjXwdo%2BnG2mmK%2BRzGc2ov9DJD2Rw%3D&reserved=0)

## Name:

**Date of Birth:**

Male

Female

## Address:

**Postcode:**

**Telephone (home): Telephone (mobile):**

**Email address:**

**Do you consent to receiving text messages?** Yes No

**Do you consent to sharing your electronic health record with the MSK service?** Yes No

**Do you consent to receiving emails from us?** Yes No

**GP Name: GP Surgery:**

**Signature: Date:**

001136

Staying the same

Worsening

Improving

**Are your symptoms:**

As a result of injury

Suddenly

Gradually

**Did your problem start:**

No

Yes

**Did it help?**

**If Yes, how long ago?**

No

Yes

**Have you had physiotherapy for this before?**

**If more than 12 weeks, how many?**

7-12 weeks

2-6 weeks

Less than 2 weeks

**How long have you had your current problem?**

Severe

Moderate

Mild

**If you are in pain, how would you describe it?**

Yes, difficulty getting to sleep

Yes, unable to sleep at all

No

Yes woken up from sleep

**Are your symptoms disturbing your sleep?**

Severely

Moderately

Mildly

Not at all

**Are your day to day activities affected by your symptoms?**

**How do your current problems affect you (on average) over the course of a week?**

**If you have answered yes to anything on the list, please give details below:**

No

Yes

**Are you a wheelchair user or do you have any other mobility issues?**

No

Yes

**Caring for a dependent:**

No

Yes

**Driving:**

No

Yes

**Playing sport:**

No

Yes

**Work:**

**Is your current problem stopping you from doing any of the following:**

**Please describe your current problem and symptoms below:**

**Please mark on the body diagram (with an X)**

**where your main problem is and where you are having symptoms**

**Physiotherapy is provided at clinics listed below. Please tick where you may wish to be treated.**

Ashfield Health and Wellbeing Centre Newark Hospital

Collingham Medical Centre Mansfield Community Hospital King’s Mill Hospital Mansfield

# Please post, email or deliver in person to:

MSK Physiotherapy Department

Ashfield Health & Wellbeing Centre Portland Street

Kirkby in Ashfield NG17 7AE

**mskr****eferralhub-admin@nottshc.nhs.uk**

Or return it to the receptionist at your GP practice