NHS CYMRU WALES – CARDIFF & VALE UHB
GPD Physiotherapy Referral

Medical Centre: W.............. Date:.................................
GP (Name)................... GP (Signature)..........................

Please submit this form by either:

Hand: RETURN TO SURGERY RECEPTION,

What next? When an appointment becomes available we will contact you. **Queries?** Call Physio Central 029 20743428

Patient Addressograph *or* Name: DOB: Address:	**Please complete *both* sides of this form as completely as possible before you submit it.** Failure to do so may result in your referral not being accepted and returned to your GP.

Physiotherapy use only

1. Please tell us what area(s) of your body your problem affects?
Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Back ☐
Hip/Groin ☐ Leg ☐ Foot ☐ Other ☐

2. To help us to diagnose & manage your current problem, it helps us if you can give a brief summary of the problem and what led to it developing, describing HOW it started and HOW it affects you:

3. How long have you had this problem?
Days ☐ Weeks ☐ Months ☐ Years ☐

4. Is the problem
New ☐ A flare up of an old problem ☐ Ongoing ☐

5. Would you say your problem is...?
Getting better ☐ Getting worse ☐ Staying the same ☐

6. Have you had any investigations for this problem (e.g. X-rays, scans, blood tests?)
Yes ☐ No ☐
If YES please give details
....
....

7. Have you had any previous treatment for this problem (e.g. medical treatment, physiotherapy, osteopathy, chiropractic)
Yes ☐ No ☐
If YES please give details including where and when
....
....

8. It helps us to have your perspective on your problem. Could you tell us any ideas or understanding you have of what might be going on or what you have been told by others about the problem?

9. In trying to help you manage your problem most effectively, it helps us to understand what you are expecting & what you think might help:
- Advice & exercises to go away with ☐
- A course of exercise in the gym/pool ☐
- A few visits with the Physio to check on your exercises and / or do some "hands on" treatment ☐
- Not sure what to expect / what might help ☐

Patient Name: .... Patient DOB: ....

Physiotherapy use only

10. How would you describe your general health?

....

It would help us if you could answer these health screening questions, so we can adapt your treatment accordingly:

- **Do you have any problems with your:**

Heart ☐ Lungs/chest ☐ Blood pressure ☐ Blood clotting ☐
Thyroid ☐ Bone density ☐

- **Are you:**

Epileptic ☐ Diabetic ☐

- **Do you have:**

Skin conditions / Eczema / Psoriasis ☐ Red, itchy or dry eyes ☐
Dry mouth ☐ Other joint problems ☐ Rheumatoid Arthritis ☐

- **Do you have any:**

Lumps / bumps / history of cancer ☐ Unexplained weight loss ☐
Family History of cancer ☐ History of smoking ☐ ....per day

- **Have you had:**

Any Major Surgery/Operations ☐ Other major medical conditions ☐

Please give details on any items you have ticked :

....
....
....

11. Please list any medications you are taking

....
....
....
....

12. To manage your problem effectively, it helps us to understand your typical daily routines (work, hobbies etc). Are you:

Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Carer ☐

Please give details...

Please give details of any sport, activities or hobbies you enjoy:

....
....

Does your current problem affect your ability to?

Work ☐ Play Sport ☐ Care for a dependent ☐ Other ☐

Please give details...

PSFS activity	PSFS score

13. Please indicate the telephone number you wish to use to communicate information and indicate if you wish for a message to be left on answer phone

	Answer phone / Voice Mail
Home Telephone:..	Y ☐ N ☐
Work Telephone:..	Y ☐ N ☐
Mobile Telephone:..	Y ☐ N ☐

14. I ____________________, confirm that the information provided above is correct to the best of my knowledge. I give consent to the physiotherapy assessment and treatment of my problem and to communication on the above. (This may be withdrawn at any time during this period).

Patient signature.. Date:....................

Physiotherapist signature.................................... Date:....................

Physio staff use only:

Priority: U R

Band: 6+ 5+ Any

Other: M F

Name:...............................