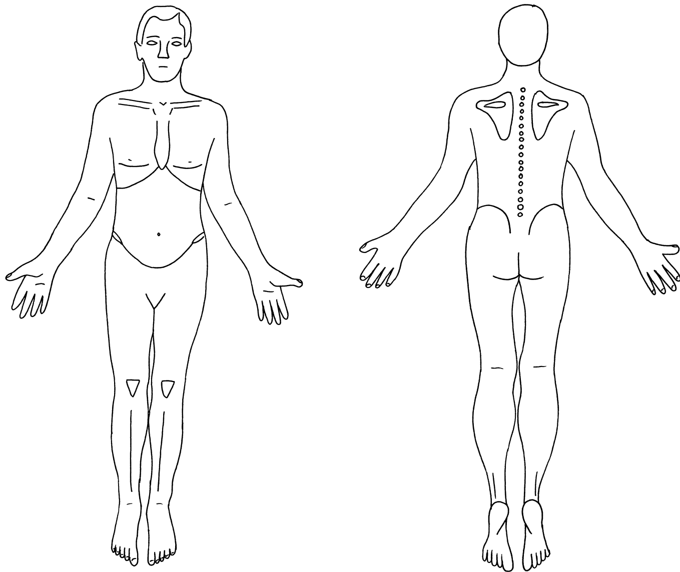
If you are making a referral regarding back pain/sciatica, have you experienced any of the following problems since your pain started?

	YES	NO
Bladder incontinence, or difficulty passing water/feeling you cannot empty your bladder (you have to force to empty your bladder)	☐	☐
A loss of bowel control (soiling yourself)	☐	☐
Numbness between your thighs/loss of sensation when using toilet paper	☐	☐
Sexual problems — loss of sensation or erectile dysfunction	☐	☐
Sciatica into BOTH legs—leg pain, pins and needles/numbness, weakness	☐	☐

If you have ticked **YES** to any of these symptoms, and you **HAVE NOT** had a medical assessment for this, it is essential you seek **IMMEDIATE (same day)** medical care by;

Calling **111,** same day appointment with GP or if required attend your local **A&E Department**

Indicate on the pictures where you get your current symptoms



Please list ALL the medication you are taking

We can offer you a Telephone Assessment whilst you are on the waiting list, please advise us if you would **NOT** like to be offered this option by ticking the box ☐

Signature ______________________ *Date* ________________

Please return this form to your preferred Physiotherapy Department:

Montgomery County Infirmary, NEWTOWN, SY16 2DW	**Tel: 01686 617207**
Victoria Memorial Hospital, WELSHPOOL, SY21 7DU	**Tel: 01938 558930**
Llanidloes War Memorial Hospital, LLANIDLOES, SY18 6HF	**Tel: 01686 414208**
Bro Ddyfi Community Hospital, MACHYNLLETH, SY20 8AD	**Tel: 01654 705221**

Physiotherapy Service Self Referral Form

GIG CYMRU NHS WALES Bwrdd Iechyd Addysgu Powys Powys Teaching Health Board

This form should only be used for patients wishing to have physiotherapy for musculoskeletal problems (back/neck pain, joint pain, soft tissue injuries).
If you are under the age of 16, you should discuss with your Health Practitioner.

Full Name (include title)

Address

Post Code

Office Use Only	
Status	**Date**
Received	
Urgent/Routine	1 hour / 1/2 hour
Partial Book sent	
Date Contacted	
Appt Given	
Did not Phone/DC	

Date of Birth: ___/___/______ Age (   )

Preferred Contact Telephone Numbers — Can we leave a message?

1. ________________ Yes / No
2. ________________ Yes / No

GP Name ______________________

Practice ______________________

______________________ PTHB Staff: Yes ☐ Location __________

Please explain why you are referring yourself to physiotherapy?

How long have you had this? Days ___ Weeks ___ Months ___ Years ___

How did it start? *(Just came on, injury, fall, long term problem etc)*

Have you been to your GP Practice for this issue? **Yes / No**

What is your occupation?

Are you off work or unable to care for a dependant because of this problem? **Yes / No**
(if yes, please give details)

What would be a successful outcome for you by attending physiotherapy?

Have you had any X-rays or other tests? **Yes / No**

Do you have any communication difficulties? **Yes / No**

PRINT CODE S.R.F NORTH LOCALITY