Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Physiotherapy Self Referral Form

Please fill out ALL 3 pages of this form and ensure you use **BLOCK CAPITALS** in **BLACK PEN.**

This service is not yet available to children under 14 or for neurological, respiratory, obstetric and gynaecological problems.

Full name:	
Address:	
Date of birth:	Phone:
GP Surgery:	Mobile: Work tel:

Which area of your body is affected? (e.g. back/knee/shoulder)

Please give a brief description of your symptoms and why you think it started (E.g. pain/swelling/stiffness).

How long have you had the problem?
……Days ……Weeks ……Months ……Years

Is this problem
New ☐ Flare up of old problem ☐ Ongoing long term problem ☐

Is your problem
Getting better ☐ Getting worse ☐ Staying the same ☐

Are you off work or unable to care for a dependent because of this problem? Yes ☐ No ☐ (If yes, please give details)

Please list **All** of the medication you are taking

What would be a good result from Physiotherapy for you?

Have you been to Physiotherapy for this before? Yes ☐ No ☐

Since the onset of problem has there been a sudden change to….	YES	NO
Bladder problems – difficulty passing water, feeling that you cannot empty or losing control of your bladder (wetting yourself)	☐	☐
Bowel problems – loss of control (soiling yourself)	☐	☐
Have you lost weight recently for reasons you cannot explain?	☐	☐

If you have ticked **YES** to any of the three symptoms above and **HAVE NOT** seen a **Doctor** for this symptom, it is essential that you arrange an **URGENT** appointment with your **GP** or call **NHS Direct** on (0845 4647) or attend your local **A&E**

DO NOT SUBMIT THIS FORM UNTIL YOU HAVE SOUGHT FURTHER ADVICE

Tick the box to confirm you have sought further advice ☐

Since the onset of this problem, do any of the following apply to you?		
	Yes	No
Severe pain at night that wakes you	☐	☐
Double vision	☐	☐
Problems swallowing	☐	☐
Does coughing or sneezing change your symptoms	☐	☐
Tinnitus (Ringing in ears)	☐	☐
Nausea	☐	☐
Headache	☐	☐
Facial Pain	☐	☐
New problems with speaking (e.g. slurring)	☐	☐
New problems with walking	☐	☐
Pins and needles anywhere	☐	☐
Numbness anywhere	☐	☐
Dizziness	☐	☐

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General Health Please complete all questions with a tick in the appropriate box							
	Yes	No		Yes	No		Yes No
Rheumatoid arthritis	☐	☐	History of cancer	☐	☐	Diabetes	☐ ☐
High blood pressure	☐	☐	Thyroid Problems	☐	☐	Heart problems	☐ ☐
Low blood pressure	☐	☐	Major Surgery	☐	☐	Pacemaker	☐ ☐
				Please add details including date of surgery.			
Lung / Breathing problems	☐	☐	Osteoporosis	☐	☐	Epilepsy	☐ ☐
Broken bones	☐	☐	Are you pregnant	☐	☐	Allergies	☐ ☐
If you have answered YES to any of the above or have any other medical problems, please provide further details here:							
Did your GP suggest you contact the service? Yes ☐ No ☐							

Patient signature: Date:

Please return this form to:

Physiotherapy Department, Amman Valley Hospital, Folland Road, Glanamman, Ammanford SA18 2BQ
Tel: 01269 820305

Physiotherapy Department, St David's Park, Jobs Well Road, Carmarthen SA31 3HB
Tel 01267 283086

Physiotherapy Department, Prince Phillip Hospital, Dafen Road, Llanelli SA14 8QF
Tel: 01554 783204