

**Occupational Health Service Physiotherapy Service:**

**Patient Completed Self Referral Form Date:**

Please read and complete all parts of this form and send via email to: OccHealth@ggc.scot.nhs.uk

**Please note that all fields on this form require to be fully completed or the form will be returned back to you and no action will be taken.**

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| Please consult your **GP URGENTLY** or **NHS 24** on **111 if you have recently or suddenly developed:**   * **Difficulty passing urine or controlling bladder/bowels** * **Numbness or tingling around your back passage or genitals** * **Numbness, pins and needles or weakness in both legs** | | | | | | **Please inform your GP of this referral if you:**   * **Have recently become unsteady on your feet** * **Are feeling generally unwell/fever** * **Have a history of cancer** * **Have any unexplained weight loss** | | | |
| Name: |  | | | | | Date of Birth: |  | | M  F |
| Address: |  | | | | | | Post Code: | |  |
| Telephone: | (home) | | (work) | | | | (mobile) | | |
| Email: |  | | Consent to receive appointment via e-mail Yes No | | | | | | |
| GP Name: |  | | GP Address: | |  | | | | |
| Post Title: | | Department: | | Directorate: | | | | Work Base: | |
| Reported to be an injury at work? Yes  No | | | DATIX reported? Yes  No | | | | RIDDOR reportable? Yes  No | | |
| Are you off work because of this problem? No Yes If yes how long:      weeks | | | | | | | | | |
| Is your pain/problem due to a recent fall or injury? No Yes | | | | | | | | | |
| Are you at risk of going off work? **No**  **Yes**  Are you able to perform your full duties? **No**  **Yes**  **Please describe your current problem and symptoms below:** | | | | | | | | | |
| **Tick one box only for each question:**  How long have you had your current problem? Please state how long if more than 12 weeks) | | | | | | | | | |
| Is your problem getting? Worse Better Not changing | | | | | | | | | |
| If in pain, how would you describe it? Mild Moderate Severe  Is your pain constant (present ALL the time)? No Yes | | | | | | | | | |
| Is pain disturbing your sleep? No  Yes, difficulty getting to sleep  Yes, woken up from sleep  Yes, unable to sleep at all | | | | | | | | | |
| Are you unable to care for/look after someone because of this problem? No  Yes | | | | | | | | | |
| Is your problem from an injury sustained during active military service? No  Yes | | | | | | | | | |
| Are your day to day activities affected by your pain? Not at all  Mildly  Moderately  Severely | | | | | | | | | |

**FOR OFFICE USE ONLY:**

|  |  |
| --- | --- |
| **Patient Name:** | **DoB:** |
| **Urgent (red flag and or further clinical information required) – Call back date** | |
| **Referral to mainstream Department (See information box for details)** | |
| **On Hold (See information box for details)** | |
| **Routine** | |
| **Additional Information (physiotherapy):**    **Clinician Name:**  **Clinician Signature**  **Designation** | |

**Occupational Health Service**

**6th Floor**

**West Glasgow ACH**

**Dalnair Street**

**Glasgow**

**G3 8SJ**

**O141 201 0600**