**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.**

|  |  |
| --- | --- |
| 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**