



Self-Referral Form

Routine physiotherapy

Please note that there is an increased waiting time for routine physiotherapy due to the Coronavirus pandemic. Please refer to the information and advice in our website to help you manage your condition effectively while you wait to hear from us.

<https://www.nhslanarkshire.scot.nhs.uk/services/physiotherapy-msk/>



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Self-referral criteria

You may use this self-referral process if:

- You live in North or South Lanarkshire
- You are aged 16 or over (if you are under 16 you will need to contact your GP about a referral)
- You are able to attend an outpatient appointment.

Completing this form will take around 10 minutes

Please post this to: Referral Management Service, Fallside Road, Bothwell, G71 8BB

Before you start

- MSK physiotherapy may not help you if you have already had physiotherapy treatment for the same condition in the past year. Please review the advice that your physiotherapist gave you and/or look at <https://www.nhslanarkshire.scot.nhs.uk/services/physiotherapy-msk/> before you complete this self-referral.
- Most initial appointments will take place face to face with follow-up appointments either by telephone, video call or face to face.
- The average number of appointments is between 1 and 3.
- You and your physiotherapist will set jointly agreed goals
- We do not accept referrals purely for acupuncture
- Your referral will be processed and added to the waiting list. Our waiting list is prioritised depending on need. Our appointment service will contact you when you reach the top of the waiting list. You may be offered an appointment at any of our NHS Lanarkshire MSK Physiotherapy departments.

If any of the statements below apply to you, please consult with a medical professional to confirm that self-referral to Physiotherapy is appropriate (For example GP or phone 111 if urgent).

This is to ensure you are seen by the right professional at the right time.

1. If you feel your condition requires medical attention
2. If you feel your condition is life threatening
3. If you have unexplained difficulty controlling or passing urine
4. If you have numbness, altered feeling or pins and needles around your back passage or genitals - for example when wiping after toileting
5. If you have recently developed sudden onset numbness, tingling or weakness in both legs
6. If you have unexplained difficulties with controlling bowel motions for example inability to stop a bowel movement or leaking
7. If you have sudden or newly worsening pain which extends below the knee in both legs
8. If you have new calf pain not related to injury with calf swelling/ calf heat/colour change in one leg with out without shortness of breath

I confirm that I do not have any of the issues listed above (Or I confirm I have consulted a medical professional about the issue and they feel Physiotherapy referral is appropriate):

Please note if this is not signed then your referral WILL NOT BE PROCESSED and it will be returned.

Completed by (PRINT NAME):
Signature:
Date:

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Step One

1. Are you completing this form for yourself or on behalf of another person?	<input type="checkbox"/> Myself ⇒ Go to Question 3	<input type="checkbox"/> On behalf of someone else
2. If you are completing this form on behalf of someone else, please provide your name and contact telephone number:	Name: Contact telephone number:	
3. Do you require an interpreter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No ⇒ Go to Question 5
4. If yes, which language/dialect?	Language/dialect:	
5. Do you require any special considerations to be made for your appointment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No ⇒ Go to Question 7
6. If Yes, please advise as to what adjustment(s) you need.	Adjustments:	

Step Two

7. Your Date of Birth (dd/mm/yyyy)	
8. Your CHI number if you know it (10 digits only i.e. 1111222333)	
9. Your Title	<input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other
10. Your Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say
11. Your First Name	
12. Your Surname	
13. Your House Number	
14. Your Street Name	
15. Your Town	
16. Your Postcode	
17. Your Email Address	
18. Your preferred contact telephone number	
19. Can a voicemail be left?	<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Home & Mobile <input type="checkbox"/> No
20. Employment Status	<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed ⇨ Please go to Question 23 <input type="checkbox"/> Retired ⇨ Please go to Question 23 <input type="checkbox"/> Student ⇨ Please go to Question 23
21. If employed, what is your occupation	
22. Are you currently absent from work because of the problem you are contacting us about?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Your Registered GP Practice	
24. Doctor Name	

Step Three

25. Where is the main site of your pain?	<input type="checkbox"/> Elbow <input type="checkbox"/> Elbow(s) <input type="checkbox"/> Foot/Feet <input type="checkbox"/> Hip(s) <input type="checkbox"/> Knee(s) <input type="checkbox"/> Lower Back <input type="checkbox"/> Lower Back and both legs <input type="checkbox"/> Mid Back <input type="checkbox"/> Lower Back and one leg <input type="checkbox"/> Neck <input type="checkbox"/> Neck and one arm <input type="checkbox"/> Neck and both arms <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Wrist/hand(s) <input type="checkbox"/> Please go to Question 27 <input type="checkbox"/> Other
26. If you have chosen, other, please tell us where your pain is	
27. How long have you had this problem for?	<input type="checkbox"/> Less than 6 weeks <input type="checkbox"/> 6-12 weeks <input type="checkbox"/> 3-6 months <input type="checkbox"/> More than 6 months
28. Have you recently been to see your GP about this problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Please go to Question 30
29. What did your GP do/advise?	
30. Do you know what has caused this problem to appear?	<input type="checkbox"/> Accident/injury <input type="checkbox"/> Other <input type="checkbox"/> Don't know
31. Please add any other details about how your problem started or how it is affecting your day to day life	
32. Is this problem getting worse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Please go to Question 35
32a. In what way is the problem getting worse?	
33. How would you describe your symptoms?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
34. Do your symptoms come and go or are they present all the time (day and night)?	<input type="checkbox"/> Come and go <input type="checkbox"/> All the time

35. Please tell us how your problem feels	
36. Are you able to carry out your normal activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes, easily <input type="checkbox"/> Yes, with some difficulty
37. Are you a registered carer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
38. Are you currently under the care of any other specialist for the same condition you are telling us about? Example: Fracture Clinic, Orthopaedics, Gynaecology, Surgery, Cancer Specialist, Rheumatology	<input type="checkbox"/> Yes <input type="checkbox"/> No
39. What height are you?	
40. What weight are you?	

Please tell us about your current health

41. Do you have any other related medical condition which you feel that the physiotherapist needs to be aware of? If so, please provide details within the free text box provided	
42. Have you had any unexpected, recent weight loss?	<input type="checkbox"/> No <input type="checkbox"/> Yes: please discuss this with your GP practice if not already known to them
43. Are you generally unwell/ have a persistent fever?	<input type="checkbox"/> No <input type="checkbox"/> Yes: please discuss this with your GP practice if not already known to them
44. Have you recently become unsteady on your feet?	<input type="checkbox"/> No <input type="checkbox"/> Yes: please discuss this with your GP practice if not already known to them
45. Do you have a history of cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes - I have not spoken to my GP We advise you discuss this with your GP practice. <input type="checkbox"/> Yes - I have spoken to my GP



Musculoskeletal Health Questionnaire (MSK-HQ)

This questionnaire is about your **joint, back, neck, bone and muscle symptoms** such as aches, pains and/or stiffness.

Please focus on the particular health problem(s) for which you sought treatment from this service.

For each question **tick (✓)** one box to indicate which statement best describes you **over the last 2 weeks**.

1. Pain/stiffness during the day How severe was your usual joint or muscle pain and/or stiffness overall during the day in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Fairly severe <input type="checkbox"/> 1	Very severe <input type="checkbox"/> 0
2. Pain/stiffness during the night How severe was your usual joint or muscle pain and/or stiffness overall during the night in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Fairly severe <input type="checkbox"/> 1	Very severe <input type="checkbox"/> 0
3. Walking How much have your symptoms interfered with your ability to walk in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Severely <input type="checkbox"/> 1	Unable to walk <input type="checkbox"/> 0
4. Washing/Dressing How much have your symptoms interfered with your ability to wash or dress yourself in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Severely <input type="checkbox"/> 1	Unable to wash or dress myself <input type="checkbox"/> 0
5. Physical activity levels How much has it been a problem for you to do physical activities (e.g. going for a walk or jogging) to the level you want because of your joint or muscle symptoms in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Very much <input type="checkbox"/> 1	Unable to do physical activities <input type="checkbox"/> 0
6. Work/daily routine How much have your joint or muscle symptoms interfered with your work or daily routine in the last 2 weeks (including work and jobs around the house)?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Severely <input type="checkbox"/> 1	Extremely <input type="checkbox"/> 0
7. Social activities and hobbies How much have your joint or muscle symptoms interfered with your social activities and hobbies in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Severely <input type="checkbox"/> 1	Extremely <input type="checkbox"/> 0

MSK-HQ – Questionnaire for joint, back, neck, bone and muscle symptoms

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8. Needing help How often have you needed help from others (including family, friends or carers) because of your joint or muscle symptoms in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Rarely <input type="checkbox"/> 3	Sometimes <input type="checkbox"/> 2	Frequently <input type="checkbox"/> 1	All the time <input type="checkbox"/> 0
9. Sleep How often have you had trouble with either falling asleep or staying asleep because of your joint or muscle symptoms in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Rarely <input type="checkbox"/> 3	Sometimes <input type="checkbox"/> 2	Frequently <input type="checkbox"/> 1	Every night <input type="checkbox"/> 0
10. Fatigue or low energy How much fatigue or low energy have you felt in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slight <input type="checkbox"/> 3	Moderate <input type="checkbox"/> 2	Severe <input type="checkbox"/> 1	Extreme <input type="checkbox"/> 0
11. Emotional well-being How much have you felt anxious or low in your mood because of your joint or muscle symptoms in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Severely <input type="checkbox"/> 1	Extremely <input type="checkbox"/> 0
12. Understanding of your condition and any current treatment Thinking about your joint or muscle symptoms, how well do you feel you understand your condition and any current treatment (including your diagnosis and medication)?	Completely <input type="checkbox"/> 4	Very well <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Slightly <input type="checkbox"/> 1	Not at all <input type="checkbox"/> 0
13. Confidence in being able to manage your symptoms How confident have you felt in being able to manage your joint or muscle symptoms by yourself in the last 2 weeks (e.g. medication, changing lifestyle)?	Extremely <input type="checkbox"/> 4	Very <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Slightly <input type="checkbox"/> 1	Not at all <input type="checkbox"/> 0
14. Overall impact How much have your joint or muscle symptoms bothered you overall in the last 2 weeks?	Not at all <input type="checkbox"/> 4	Slightly <input type="checkbox"/> 3	Moderately <input type="checkbox"/> 2	Very much <input type="checkbox"/> 1	Extremely <input type="checkbox"/> 0

Physical activity levels

In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your heart rate?

This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that is part of your job.

None 1 day 2 days 3 days 4 days 5 days 6 days 7 days

Thank you for completing this questionnaire.

The MSK-HQ total score is the sum of items 1-14, using the response values provided.

MSK-HQ – Questionnaire for joint, back, neck, bone and muscle symptoms

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