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| GP PHYSIOTHERAPY REFERRAL FORM |  |
| **St George’s Hospital /St John’s Therapy Centre/ Queen Marys Hospital**Tel: 020 8725 0007 This form can be used to refer:* Wandsworth patients to the Neuro and Respiratory Physiotherapy Services.
* Woman and Men’s Health Physiotherapy Service for non MSK conditions, e.g. continence
* MSK patients outside of Wandsworth

Please email referrals to stgh-tr.referrals@nhs.netAll Wandsworth MSK physiotherapy referrals must be sent via the Single Point of Access on e-Rs.  |
| **GP / PCT DETAILS: Please complete IN CAPITALS** |
| GP Name: (PRINT)PCT ID: | Surgery Address / Stamp: (PRINT) |
| **PATIENT’S DETAILS: Please complete IN CAPITALS** |
| **Staff member at St Georges Trust?** Yes 🞏 No 🞏 |
| SGH HOSPITAL NO: | NHS NUMBER: | DOB: | SEX:  |
|  |  |  | Male 🞏 | Female 🞏 |
| PATIENT’S SURNAME: | PATIENT’S FULL ADDRESS: |
|  | POSTCODE: |
| PATIENT’S FORENAME: |
|  |
| Home Tel: |  |
| Mobile: |  | INTERPRETER REQUIRED?If Yes, which Language?  |  Yes 🞏 No 🞏 |
| Work Tel: |  |
| **CONSENT TO LEAVE TELEPHONE MESSAGE?** |  Yes 🞏 No 🞏 |   |
| **Occupation** |  |
| **OFF WORK DUE TO THE****PROBLEM?**  |  Yes 🞏 No 🞏 | **DISTURBED SLEEP DUE****TO THIS PROBLEM?** |  Yes 🞏 No 🞏 |
| **TIME SINCE ONSET:****Specify Other:** | LESS THAN SIX WEEKS 🞏  | **FLARE UP OF CHRONIC CONDITION?** |  Yes 🞏 No 🞏 |
| OTHER 🞏 |
| DIAGNOSIS / OPERATION DATE AND DETAILS:  | SCAN / X-RAY FINDINGS: |
| REASON FOR REFERRAL: | OTHER RELEVANT INFORMATION: |
| REFERRER’S SIGNATURE: | DATE: |