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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.net](mailto:stgh-tr.referrals@nhs.net)  All 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: | | | |