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| PELVIC HEALTH PHYSIOTHERAPY REFERRAL | | | | | | L:\Files\Service Improvement & Strategy\Marketing\GP LIAISON\Logos\NHS_SGUHFT_rgb_R1.jpg | | |
| Internal referrals send to: [nmskoutpatientpathwayhub@stgeorges.nhs.uk](mailto:nmskoutpatientpathwayhub@stgeorges.nhs.uk)  External referrals send to: [Stgh-tr.nmskpathwayhub@nhs.net](mailto:Stgh-tr.nmskpathwayhub@nhs.net) Tel: 020 8725 0007 | | | | | | | | |
| **GP / PCT / CONSULTANT DETAILS: Please complete IN CAPITALS** | | | | | | | | |
| Referrer Name (GP/Consultant Name): (PRINT)  Designation: Signature:  Speciality/ Team: Date: | | | | | GP Name and Full GP Address: (PRINT)  PCT ID: | | | |
| **PATIENT’S DETAILS: Please complete IN CAPITALS** | | | | | | | | |
| **SGH HOSPITAL NO:** | | | | **NHS NUMBER:** | **DOB:** | | **SEX:** | |
|  | | | |  |  | | Male 🞏 | Female 🞏 |
| **PATIENT’S SURNAME:** | | | | | **PATIENT’S FULL ADDRESS or HOSPITAL LABEL:** | | | |
|  | | | | | POSTCODE: | | | |
| **PATIENT’S FORENAME:** | | | | |
|  | | | | |
| **Home Tel:** |  | | | |
| **Mobile:** |  | | | | **INTERPRETER REQUIRED?**  **If Yes, which Language?** | | Yes 🞏 No 🞏 | |
| **Work Tel:** |  | | | |
| **CONSENT TO LEAVE TELEPHONE MESSAGE?** | | | Yes 🞏 No 🞏 | |  | |
| **OFF WORK DUE TO THE**  **PROBLEM?** | | | Yes 🞏 No 🞏 | | **OCCUPATION:** | |  | |
| **TIME SINCE ONSET:**  **Specify Other:** | | LESS THAN SIX WEEKS 🞏 | | | **IS ST GEORGE’S HOSPITAL YOUR HOSPITAL OF CHOICE FOR PHYSIOTHERAPY?** | | Yes 🞏 No 🞏  If no please refer to hospital of choice. | |
| OTHER 🞏 | | | | | | |
| DIAGNOSIS / OPERATION DATE AND DETAILS (e.g. PGP, prolapse, stress urinary incontinence, urgency): | | | | | INVESTIGATION FINDINGS (e.g. DVE, UDS, 4D scan): | | | |
| REASON FOR REFERRAL/ PRESENTING SYMPTOMS:  AQ: | | | | | **COMPLETE IF PREGNANT/ POST NATAL:**  **Gestation: /40**  **Number of Weeks Postnatal: /52** | | | |

**FOR THERAPY OFFICE USE ONLY:**

|  |  |
| --- | --- |
| CBS STAMP |  |