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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 External referrals send to: 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:**

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| CBS STAMP |   |