Occupational Health Service

EARLY ACCESS PHYSIOTHERAPY REFERRAL FORM

**Private and Confidential**

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| **PART ONE - To be completed prior to Physiotherapy treatment** |

Name

Department

Telephone Email

1. Referred by: self [ ]  OH [ ]
2. Reason for referral

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1. Are you currently: at work [ ]  off work [ ]
2. How long have you had symptoms?

<2 weeks [ ]

* 1. weeks [ ]
	2. weeks [ ]

>8 weeks [ ]

1. Have you needed to take time off in the past 2 years because of symptoms? Yes [ ]  No [ ]
2. Have you had physiotherapy during this time? Yes [ ]  No [ ]
3. Are you on a waiting list? Yes [ ]  No [ ]

If Yes, how long waiting?

<2 weeks [ ]

* 1. weeks [ ]
	2. weeks [ ]

>8 weeks [ ]

1. Have you seen your GP or other healthcare professional? Yes [ ]  No [ ]
2. What treatment if any are you receiving?

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|  |

1. Please grade on the scale below the impact of your symptoms on your general activity?

0 1 2 3 4 5 6 7 8 9 10

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 No Impact Moderate Impact Severe Impact

1. Please grade on the scale below the impact of symptoms on the ability to do your job?
2. 1 2 3 4 5 6 7 8 9 10

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 No Impact Moderate Impact Severe Impact