Self Referral to Obstetric Physiotherapy – In Confidence

Please fill out both sides of this form as fully as you can and return to the receptionist at your GP Practice or local Physiotherapy Department

Date: ……..

No. of weeks pregnant …… No of previous pregnancies ……..
Expected due date ……

Section 1: Your Details

Name: …… DOB: ……..

Address: ……..
…….. Post Code: ……..

Day time contact number: …… CHI: ……

GP Name and Health Centre: ……..

Do we have your permission to contact your GP? ☐ Yes ☐ No

Section 2: Reasons for referring

1. Please describe briefly why you are seeking Physiotherapy assessment
   ……

1. How long have you had this current problem? ……..

2. Have you had this problem before ☐Yes ☐No
   If yes, did you receive physiotherapy? ☐Yes ☐No
   If yes, did physiotherapy help? ☐Yes ☐No

3. Are the symptoms overall getting ☐Better ☐Worse ☐Just the same

4. Do they disturb your sleep? ☐Yes ☐No
   If yes how often and for how long e.g. 2 x per night for 20 mins for 3 weeks
   ……

5. Are you able to perform your normal daily activities? ☐Yes ☐No ☐With difficulty
   Please give details: ……..

6. Are you off work with this condition? ☐Yes ☐No ☐Not working

7. If a full time carer (include childcare), is this condition affecting your ability to carry out your daily commitments? ☐Yes ☐No ☐With difficulty

8. Have you had any recent investigations? ☐Yes ☐No
   If yes please provide brief details and results if known
   ……

9. Please list any medications you are taking at the moment
   ……

Section 3

Please answer the following questions **only** if your referral is about a **neck or back problem, with or without leg pain/arm pain**
Are you experiencing symptoms of:

Unexplained changes with your bowel/bladder function - such as change in frequency/retention (unable to go) or lack of control ☐Yes ☐No

Numbness or reduced sensation between your legs or around your genitals/groin ☐Yes ☐No

Unexplained or new weakness in your legs/tripping/catching your feet ☐Yes ☐No

Constant pain, pins and needles or numbness below **both** knees or Below both elbows ☐Yes ☐No

If you have answered yes to any of these questions, we advise that you inform your GP of these specific concerns immediately.

Section 4

Please answer the following questions **only** if your referral is about a **neck or arm problem, such as pain or weakness**
Are you experiencing symptoms of:

Headaches – **New, unexplained or increased** from your normal headache pattern ☐Yes ☐No

Dizziness – **more so than your normal** or **new recurrent episodes** within the last 3 months ☐Yes ☐No

Unexplained blurred, double vision or loss of vision or a drooping eyelid ☐Yes ☐No

Fainting/falling/blacking out **without reason** ☐Yes ☐No

Unexplained difficulties swallowing or talking – such as slurred speech ☐Yes ☐No

Changed feeling or weakness around your face/tongue ☐Yes ☐No

New or persistent difficulty in doing small tasks with **both** of your hands, for example buttoning your shirt or gripping ☐Yes ☐No

New onset of hearing problems such as a sudden loss of hearing or pulsating ringing noise in your ears ☐Yes ☐No

If you have answered yes to any of these questions, we advise that you inform your GP of these specific concerns immediately.

Signature …….. Date ……

Please remember to bring your pregnancy notes

Named Midwife: ……

Named Consultant (if you have one): ……