

**OUTPATIENT THERAPY REFERRAL FORM**

Is the referral for?

Physiotherapy  Occupational Therapy  Both

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Surname |  | Patient Title |  | Date of Birth |  |
| Forename(s) |  | Gender |  | Ethnicity |  |
| Address (inc Postcode) | | NHS No |  | UBRN |  |
| Preferred Tel No |  | Tel Home |  | Tel Mob |  |
| Patient email |  | | | | |
| Referring GP |  | | | | |
| Practice Name and address |  | | | | |
| Practice Tel No |  | | | | |

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| Details of main complaint (include nature, onset of symptoms, severity, first episode or recurrent management to date etc) |

Has the patient been referred for the same complaint within the last 6 months? Yes/No

Is the patient currently off work due to their symptoms? Yes/No

Is the patient unable to care for a dependent due to their current symptoms? Yes/No

Have any other referrals to other services been made for this same complaint? Yes/No

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| Please give details |

Does the patient require an interpreter? Yes/No

Is the patient currently pregnant? Yes/No

NHS No:

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| Please give details of any relevant investigations |
| Medications *(Please list or attach current medications if possible)* |

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| Any other relevant information? |