Community Physiotherapy Referral Form

Please complete all sections as appropriate.

Patient details

Patient's Name: Unit Number:

Address: Date of birth:

Sex: Male / Female

Post code: Next of Kin contact details:

Day telephone number:

Reason for referral
(state what needs to be assessed, provided, or treated)

Opinion on urgency

High ☐
Moderate ☐
Low ☐

History of present condition (HPC) **Duration of current problem?** ....

Has patient been recently discharged from hospital? Date ....

Has the patient received Physiotherapy for this same problem before? Yes ☐ No ☐

Past medical history (in addition to HPC)

Social Circumstances

Lives alone ☐ / with ....
Is patient able to answer the door? **Yes** ☐ **No** ☐ Intercom ☐ Key safe ☐ Warden ☐
Does patient rely on support services? (eg. Home Care, MOW, District Nurse) No/Yes
Please state

To ensure safety is there anything that a visiting therapist should know about?

GP details

Name *(Please print)*:

Address/Practice Stamp:

Tel. No:

Referrer details

Name and title *(Please print)*:

Tel. No:

Date of referral

Please fax this completed form to: 01702 221024 or send
To Community Physiotherapy team, Rehabilitation Dept.,
Southend Hospital. SS0 0RY

Office use only
Date received ....
P1 P2 P3 Therapist =