**Hand and Wrist Self-Referral Form - Horsham**

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| You must be aged 17 years to be seen by the SMSKP Hand and Wrist Service. **If you are under 17, please contact your GP for advice.**  Please complete all parts of this form in **black ink** and hand in or send to:  Physiotherapy Department, Horsham Hospital, Hurst Road, Horsham, West Sussex, RH12 2DR  You can also complete this referral online. Please visit: <http://sussexmskpartnershipcentral.co.uk/hand-and-wrist/> | |
| **Important Notice** | |
| **Do Not continue with this form but make an appointment to discuss this referral with your GP if you:**   * Have symptoms which include pins and needles or numbness affecting **both** hands * Have significant swelling and/or bruising associated with a recent fall * Have noticed any new lumps or bumps associated with your hand or wrist * Have history of cancer within the last 5 years * Any unexplained weight loss * Are feeling generally unwell/fever * Have recently become unsteady on your feet | |
| Personal Details | |
| Title Click here to enter text.  Full First Name(s) Click here to enter text.  Surname Click here to enter text.  Date of Birth Click here to enter a date. | Address Click here to enter text.  Click here to enter text.  Click here to enter text.  Postcode Click here to enter text. |
| Telephone (please tick preferred number)  Home Click here to enter text.  Mobile Click here to enter text.  Work Click here to enter text. | e-mail address Click here to enter text.  Are you happy to receive correspondence via email?  Yes No  Are you happy for a message to be left on your phone?  Yes No |
| GP Name Click here to enter text.  NHS Number (if known) Click here to enter text. | Did you GP advise you to complete this form?  Yes No |
| GP practice  Courtyard Surgery Orchard Surgery Riverside Surgery The Village Surgery Southwater  Holbrook Surgery Park Surgery Rudgwick Medical Centre Other  If you selected “Other”, please specify Click here to enter text. | |
| Do you have any special requirements?  Sight impairment Hearing impairment Learning Disability  Speech impairment Behavioural and Emotional Other  Interpreter (please specify language) Click here to enter text.  If you selected “Other”, please specify Click here to enter text.  Please give details of how we can help you Click here to enter text. | |
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| About your current problem | |
| Is your pain or problem related to a recent injury or fall? Yes No  Is this problem related to a current or previous active service in the arm forces? Yes No | |
| Are you pregnant?  Yes No | If yes have your symptoms come on since the start of the pregnancy?  Yes No |
| Where is your problem? Please tick a maximum of 4 boxes  Neck Elbow Fingers  Upper Arm Wrist Palm  Lower Arm Thumb Other  If you selected “Other”, please specify Click here to enter text. | |
| Please describe your current symptoms, including how they started, any pain, weakness or altered sensation  Click here to enter text. | |
| How long have you had your current symptoms?  Less than 2 weeks 2-6 weeks 6-12 weeks  3-6 months More than 6 months Other  If you selected “Other”, please specify Click here to enter text.  Please give details of how we can help you Click here to enter text. | |
| Is your pain getting  Better Staying the same  Worse Other  If you selected “Other”, please specify Click here to enter text. | |
| Is your pain constant (present all the time with no relief)? Yes No | |
| On a scale of 0-10 (with 0 being no pain and 10 being the worst pain you have experienced), how would you score your symptoms? Please circle as appropriate  Today 1 2 3 4 5 6 7 8 9 10  At best 1 2 3 4 5 6 7 8 9 10  At worse 1 2 3 4 5 6 7 8 9 10 | |
| Have your recent symptoms affected your sleep pattern? Yes No  If so, how often is this occurring? Click here to enter text. | |
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| Does your problem get worse at any particular time of the day or night? Yes No  Comments Click here to enter text. |
| Are your day to day activities affected by your pain?  Not at all Mildly  Moderately Severely |
| Are you off work because of this problem? Yes No  If so, how long for? Click here to enter text. |
| Are you unable to care for someone because of this problem? Yes No  If so, please give detail Click here to enter text. |
| Please list any medication you are taking for this current problem (e.g. painkillers/ anti-inflammatories)  Click here to enter text. |
| Have you been seen by a specialist for this problem? Yes No  If so who did you see and when?  Click here to enter text. |
| Have you had these or similar problems in the past? Yes No  If yes how long ago and how was it managed at the time?  Click here to enter text. |
| Have you been diagnosed with Carpal Tunnel Syndrome or do you experience pins and needles or numbness across the tips of the thumb, index and middle fingers? Yes No  Comments Click here to enter text. |
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| **Patient Rated Wrist and Hand Evaluation** |
| The questions below will help us understand how much difficulty you have had with your wrist/hand in the past week. You will be describing your **average** wrist/hand symptoms **over the past week** on a scale of 0-10. Please provide an answer for **ALL** questions. If you did not perform an activity, please **ESTIMATE** the pain or difficulty you would expect. If you have never performed the activity, you may leave it blank. |
| Pain: Rate the average amount of pain in your hand/wrist **over the past week** by circling the number that best describes your pain on a scale from 0-10. A **zero** (0) means that you **did not have any pain** and a **ten** (10) means that you had **the worst pain you have ever experienced**.  At rest 1 2 3 4 5 6 7 8 9 10  When doing a task with repeated  wrist/hand movement 1 2 3 4 5 6 7 8 9 10  When lifting a heavy object 1 2 3 4 5 6 7 8 9 10  When it’s at its worst 1 2 3 4 5 6 7 8 9 10  How often do you have pain 1 2 3 4 5 6 7 8 9 10  (0=never, 10=always) |
| Function: A: Specific Activities: Rate the **amount of difficulty** you experienced performing each of the items listed below, over the past week, by circling the number that best describes your difficulty on a scale of 0-10. A **zero** (0) means you did not experience any difficulty and a **ten** (10) means it was so difficult you were unable to do it at all.  Turn a doorknob using my affected hand 1 2 3 4 5 6 7 8 9 10  Cut meat using knife in my affected hand 1 2 3 4 5 6 7 8 9 10  Fasten buttons on my shirt 1 2 3 4 5 6 7 8 9 10  Use affected hand to push up from a chair 1 2 3 4 5 6 7 8 9 10  Carry a 10pound object in my affected hand 1 2 3 4 5 6 7 8 9 10  Use bathroom tissue with my affected hand 1 2 3 4 5 6 7 8 9 10 |
| Function: B: Usual Activities: Rate the **amount of difficulty** you experienced performing your **usual** activities in each of the areas listed below, over the past week, by circling the number that best describes your difficulty on a scale of 0-10. By “usual activities”, we mean the activities that you performed before you started having a problem with your hand and wrist. A **zero** (0) means you did not experience any difficulty and a **ten** (10) means it was so difficult you were unable to do any of your usual activities.  Personal Activities (Washing, Dressing) 1 2 3 4 5 6 7 8 9 10  Household Maintenance 1 2 3 4 5 6 7 8 9 10  Work (your job or everyday work) 1 2 3 4 5 6 7 8 9 10  Recreational Activities 1 2 3 4 5 6 7 8 9 10 |
| Appearance: (Optional)  How important is the appearance of your hand? Very Much Somewhat Not at all  Rate how dissatisfied you were with the appearance or your wrist/hand during the past week.  1 2 3 4 5 6 7 8 9 10 |
| Thank you for completing this form.  If you have not heard from us within 4 weeks please contact us on 0300 303 8063 |

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