Please note - If you are under 16, have recently had surgery or have multiple joint or muscle pains please do not complete this form but seek assistance from your GP

Please email the completed form to vcl.lutonmsk@nhs.net

First Name:			Title:		
Surname:					
Date of Birth:					
Address (incl. Postcode)					
Telephone Number:					
Email:					
Mobile Number:					
GP Name					
GP Address					
Who is completing this form:	Myself:		Other, relationship to the patient		
Do you require and interpreter	Yes		No		Which Language:
Have you been signed off work for this problem?	Yes		No		How Long?
Are you unable to care for anyone because of this problem?	Yes		No		
Are you unable to sleep because of this problem?	Yes		No	How many nights per week?	
Can you explain and describe your problem(s)					

Do you have any pins and needles or numbness	Yes		No	If so where?
How did this start?				
What date did this start?				
Has it changed since starting	Better	Worse	Same	
Have you had any treatment for this problem recently or in the past?				
Have you seen your GP about this problem?	Yes		No	

Relevant medical history, please tick yes or no for all the following		
Condition	**Yes**	**No**
Thyroid problems		
Heart Problems		
Family history of Rheumatoid Arthritis		
Epilepsy		
Lung Problems		
Diabetes		
Major illness		
Cancer (past or present)		
Fractures		
Osteoporosis		
Do you smoke?		
Have you ever taken steroids?		
Have you ever taken blood thinners?		
Have you had any tests for <u>THIS</u> problem?		
X-ray		
MRI/CT Scan		
Ultrasound scan		
Blood Tests		
Other Tests		
Please list your current medication		

Only answer these questions if your referral is for a low back problem OR pain in your legs coming from your back. Please answer carefully as they relate to important nerves that come from your back and may require immediate attention.

Since your low back pain started, or if it has worsened, please indicate if you have had any changes regarding the following:			
1. Have you had any loss of sensation or altered sensation in your vaginal/genital area or back passage? (i.e. noticed any change is sensation when you wipe yourself after going to the toilet OR change in sensation with sexual intercourse?)	Yes	No	Unsure
2. Have you had any change in your bladder or bowel function? (i.e. incontinence or loss of control/increased frequency or being unable to go to the toilet?)	Yes	No	Unsure
3. Have you had any changes in sexual function? (i.e. are you still able to achieve and maintain an erection, do you have normal sensation during sexual intercourse?)	Yes	No	Unsure

*****IF YOU HAVE ANY OF THE ABOVE YOU MUST CALL 111 OR ATTEND A&E IMMEDIATELY *****

In some cases, you may be required to see your GP for further assessment prior to being referred into the service, in which case we will contact you and let you know.