Physiotherapy Referral Form

Carpal tunnel appliance assessment requiring full physiotherapy assessment

Patient Details

Please affix patient label Name: CHI: GP:

Referral date: _____

Referring support worker & Site

_____

_____

Patients Preferred Contact Number

☎:_____

Reason for referral

Patient scored _____ on Hems questionnaire

Symptoms

Duration of symptoms:	

Symptoms are:	Worsening ☐	Improving ☐	Not changing ☐
Pain is:	Mild ☐	Moderate ☐	Severe ☐

Pain is constant:	Yes ☐	No ☐
Sleep is disturbed:	Yes ☐	No ☐

Off work due to symptoms:	Yes ☐	No ☐	If yes how long? _____

ADL affected:	Not at all ☐	Mildly ☐	Moderately ☐	Severely ☐

Evidence of cervical root irritation:	Yes ☐	No ☐
Paraesthesia/ anaesthesia not in the median nerve distribution:	Yes ☐	No ☐
Weakness/ clumsiness:	Yes ☐	No ☐