



11. Please list any medications you are taking at the moment

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**Section 3:-** Have you experienced any :-

- 1. Changed feeling e.g. tingling on touch.....Yes No
- 2. Changed feeling between your legs.....Yes No
- 3. Unexplained tripping/stumbling/leg weakness.....Yes No
- 4. Unexplained changes in your bladder/ bowel.....Yes No  
E.g. Frequency /Retention or unable to go/Lack of control in going
- 5. Loss of weight without trying.....Yes No  
Current weight .....
- 6. Unexplained /increased headaches.....Yes No
- 7. Dizziness.....Yes No
- 8. Unexplained blurred or double vision.....Yes No
- 9. Changed feeling around face or tongue.....Yes No
- 10. Fainting/Falling without reason.....Yes No
- 11. Difficulties in swallowing/talking.....Yes No
- 12. General unwell-ness .....Yes No
- 13. Loss of appetite .....Yes No
- 14. New muscle weakness .....Yes No

**If you find your symptoms get worse while you wait for an appointment you are advised to see your GP.**

Signature:.....Date: .....

**Please return your completed self-referral form to the receptionist at your GP practice or your local physiotherapy Department**

For office use only:					
Urgent	Semi-urgent	Routine	Yellow	Red	Suitable for student Y/N
Date Received			Letter to GP		
CHI No.			Recorded on Epex		
Transport required					