INPATIENT
Physiotherapy Application Form

PERSONAL INFORMATION

Surname:	Forenames:
D.O.B	Gender (please tick) Male ☐ Female ☐
Current Police Force (if retired, previous force)	If serving Date joined Collar Number
If retired Date of Retirement:	Police pension number:
Home Address:	Home telephone: Mobile telephone:
Postcode:	Email:

NEXT OF KIN

Name	
Relationship	Contact telephone number

DATES TO AVOID

(Please include all leave/holiday, court or other commitments)

LEGAL CLAIMS:

Has the applicant any legal claims pending or contemplated in their current circumstance (please tick)

Yes ☐ No ☐

WHICH APPLIES

Please indicate which of the following applies to the applicant (please tick)

Work ☐ Recuperative duties ☐ Restricted duties ☐ Sick leave ☐

PLEASE NOTE It is important that you notify the centre as soon as possible if you are unable to attend your appointment.
Contact number regarding all appointments: 01254 244980

APPLICANT'S CONDITION

Please briefly describe the applicant's condition e.g. accident/event at work/post -operative/long-term illness/other

SURGERY / OTHER INTERVENTIONS

Time length including onset of condition/dates of any surgery or other interventions

PREVIOUS OR ONGOING TREATMENT

Previous or ongoing treatment in relation to this condition e.g. other therapy services

SERVICES USED

Has the applicant used our service before (please tick)

St Michaels Lodge ☐ Cheshire HQ ☐ Merseyside Fed ☐ Cumbria Fed ☐ Progress house ☐

Date from:	If **YES**, was this for the same condition (please circle) Yes ☐ No ☐
Has the applicant attended within the last 6 months or awaiting to attend the services at the PTC/Auchterarder for this condition	Yes ☐ No ☐ Date:

PLEASE NOTE If available; Please bring any treatment protocols/ X-rays/ scans/ medical reports that may be of benefit to our physiotherapists.

PERSONAL INFORMATION

Do you require an additional carer/nurse to attend with you during your stay? Yes ☐ No ☐

Do you have limited mobility i.e. use of a wheelchair/walking aids? Yes ☐ No ☐

Do you take medication Yes ☐ No ☐

Current medication

Do you have allergies/infections Yes ☐ No ☐

Do you have any dietary requirements Yes ☐ No ☐

Past medical history

CARER/NURSE DETAILS

Name:

Telephone No:

Limited Mobility: Yes ☐ No ☐

If **YES**, please state:

Medication Yes ☐ No ☐

If **YES**, please state

Limited Mobility: Yes ☐ No ☐

If **YES**, please state:

Dietary requirements: Yes ☐ No ☐

If **YES**, please state:

PERSONAL INFORMATION

The information which you supply to us may be used to make admission and clinical decisions; for audit and statistical analysis; for fraud prevention.

☐ I understand that all personal information on this form will be confidential to the professional and administrative staff of the NWPBF and no personal information or clinical reports will be shared without my express consent unless required by law.

☐ I agree to include any claim for damages pursued by me against the third party in respect of the accident resulting in my injury such as sums specified by the NWPBF.

☐ I agree to the NWPBF contacting me using the details I have provided

Signature

Date

Signature of: Force medical officer / Occupational health nurse / Physiotherapist / G.P / Consultant / Medical practitioner

Please note this must be signed within the last 3 months

Certified by (signature):	Print Name:
Date:	Job Title:
Address:	Post Code:
Tel No:	Email:

OFFICE USE ONLY

Certified by (signature):	
Name:	Department:
Addition information:	
Date received:	Donation check:
Date on system:	Date @ physio: