

# OUTPATIENT Physiotherapy Application Form



Please tick the centre you wish to attend:

St Michaels Lodge  Cheshire HQ  Merseyside Fed  Cumbria Fed  Progress house

## 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

Police pension number:

Date of Retirement:

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

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

## MEDICAL APPROVAL INFORMATION

**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: