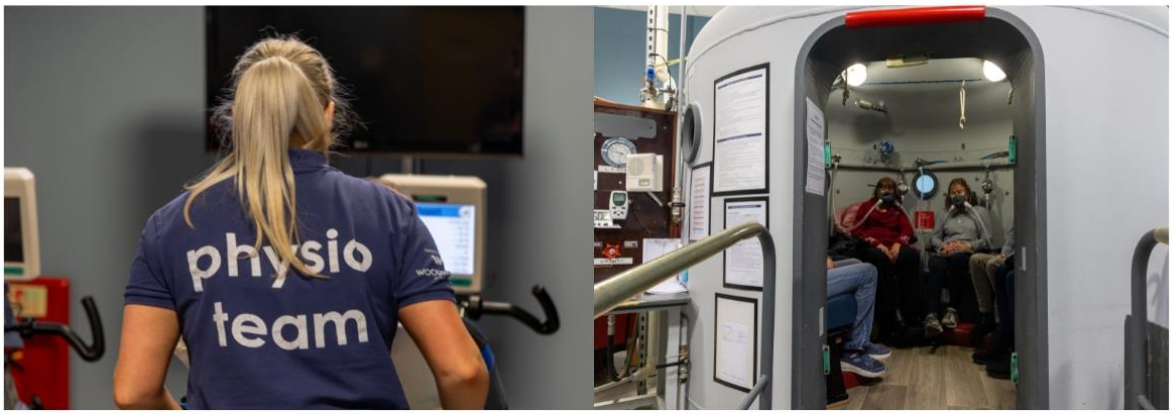
the brightwell

a centre for neurological wellbeing & physical recovery

Clinical Pack



A centre for neurological wellbeing & physical recovery

Our aim is to offer a diverse range of specialised therapies, including Hyperbaric Oxygen Therapy (HBOT) and Neuro-physiotherapy, all delivered by a dedicated team of experts.

The Brightwell is a partnership of the following organisations that support people with neurological conditions:

The West of England MS Therapy Centre Limited - Charity No. 801155

The Bristol Therapy Centre Ltd - Company No 08193674

The Brightwell Neurological Support Centre - Charity No. 1109459

Contact Us

The Brightwell
Bradbury House, Wheatfield Drive
Bradley Stoke, Bristol, BS32 9DB

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scan for more information

The Brightwell,
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STRICTLY CONFIDENTIAL

GENERAL/HEALTH PRACTITIONER INFORMATION FORM

Your patient would like to access therapy at The Brightwell to help them manage their condition more effectively.

So that we can advise as to which therapy/therapies may be the most suitable for them, we would be grateful if you could confirm their primary diagnosis on the form below and **return it to us along with a printed medical history summary** and list of current medications. We kindly ask that you do not charge your patient for fulfilling this request. If you have any questions or concerns, please contact us using the details above.

PATIENT INFORMATION - please complete using **BLOCK CAPITALS**.

Title:			
Full NAME:			
Address:			
		Postcode:	
Date of Birth:		**Contact Tel:**	

Diagnosis/any other information and comments (please complete using BLOCK CAPITALS):

☐ I have included a medical summary (please tick to confirm)

(additional space is provided overleaf)

I understand that this note is not a referral and does not indicate an endorsement of the treatments available.

Signed (G.P.)…….. Date ……

Name of G.P. (please PRINT)

……

PRACTICE STAMP, for verification:

The Brightwell is a partnership of:

The West of England MS Therapy Centre

Registered Charity No: 801155

& The Bristol Therapy Centre

Company No: 08193674

The Brightwell provides therapies and support for people living with a neurological condition such as Multiple Sclerosis, Parkinson's Disease, Fibromyalgia, ME, or stroke. If you would like to learn more about what we do please visit our website, thebrightwell.org.uk or contact us.

There are over 50 MS Therapy Centres in the UK and Ireland who all operate as individual charities to offer advice, information, and a range of therapies to people with MS or other neurological conditions. The first Centre was established in 1982, and since then more than 2 million oxygen sessions have been provided without incident.

This treatment is supported by controlled trials.

For more information visit www.neurotherapynetwork.org.uk

Diagnosis/any other information continued:

Subjective Assessment Form

Name:	Gender:
Date of Birth:	Date:

All your data will be kept confidential and will be legitimately processed for the purposes of guiding and informing your treatment at The Brightwell in line with GDPR (2018). Our full Data Protection Policy (PP36) is available in our members' information and is also available on our website.

Please specify your **Primary Diagnosis**:	
How long have you had your illness?	

Medical History:

Do you have any significant past medical history?	Y/N
Please give brief details if you answered 'Yes':	
Are you allergic to any substances? Please give details if you answered 'Yes':	Y/N

Current Concerns & goals:

What are your main issues at present? Please give brief details: What are your main goals from treatment?

Medications:

Please list your current medications, including dosage and frequency:

Symptoms:

1. Are you experiencing any vision issues?	Y/N
2. Do you have any breathing difficulties?	Y/N
3. Do you have communication issues, e.g. difficulties with speech, reading, or writing?	Y/N

4. Are you experiencing any issues with swallowing?	Y/N
5.Do you have any pain?	Y/N
If yes, please specify the location, quality (e.g., sharp, dull, burning), and intensity:	
6. Fatigue: a) Are you affected by fatigue or tiredness that impacts your work or home life?	Y/N
b) What factors affect your fatigue? (e.g. Heat, Cold, Stress, Physical Activity)	
7. Skin Issues: Do you have any skin issues such as pressure sores?	Y/N
8. Spasms, Muscle Stiffness, and High Tone: Do you experience spasms, muscle stiffness or high tone? If yes, please specify the location.	Y/N
9. Coordination: Do you suffer from tremors or shaky/jerky movements?	Y/N
10. Bladder Issues: a) Are you experiencing bladder issues such as urgency, frequency, retention, constipation, or infection?	Y/N
b) Do you use any appliances (CATHETER/ SUPRAPUBIC/CONVENE/STOMA BAG)? Please state what you use:	Y/N
11. Daily activities: Do you have difficulty with daily activities such as washing, dressing, cooking, or shopping?	Y/N
12. Do you have difficulty using your hands?	Y/N
13. Balance and Walking: a) How would you describe your balance while sitting?	(POOR/FAIR/GOOD)
b) How would you describe your balance while standing?	(POOR/FAIR/GOOD)
c) Do you experience dizziness or unsteadiness?	Y/N
14. Falls: a) Have you experienced any falls in the past that caused a major injury?	Y/N
Please provide a brief explanation of the injury:	
b) How frequently do you experience falls? (Daily/Weekly/Monthly/Yearly)	

c) How do you get up after a fall? (INDEPENDENTLY/PHYSICAL ASSISTANCE/ EQUIPMENT)	
d) Do you have any underlying conditions such as Postural Orthostatic Hypotension, Vestibular disorders, or Cardiovascular conditions?	Y/N
15. Mobility: a) How often do you require assistance with walking?	
b) Can you climb stairs? If so, how many?	
c) Do you use any assistive devices (e.g., cane, walker, wheelchair)?	
d) Are you able to navigate outdoors within the local community?	Y/N
16. Mood and behaviour concerns and worries: a) Are you experiencing any mood issues such as feeling sad, anxious, or depressed?	Y/N
b) Do you have any Personality, Relationship, or behavioural concerns?	Y/N
17. Sleeping Issues: Do you have any sleeping issues? Please provide details:	
18. Memory, Planning, & Concentration: Are you experiencing any issues with memory, planning, concentration, or motivation? Please give details:	
19. Circulation: Do you have, or have you ever had, circulatory issues including embolism, thrombosis, or Raynaud's condition?	Y/N
20. Social Activities and Work: How often do you engage in social activities and work?	
21. Accommodation: Please describe your current living accommodation? (e.g. flat, house, bungalow, care facility etc).	

22. Please indicate any other treatments that you are interested in:

Acupuncture ☐	Oxygen ☐	Physiotherapy ☐
Reflexology ☐	Counselling ☐	Exercise Class ☐
Group Class ☐	Mindfulness ☐	

Name:	Gender:
Date of Birth:	Date:

Body Chart: Please label diagram according to symptoms listed below:

Pain = P Numbness = O Pins & Needles = P + N Weakness = W Sensation = S	Made Worse by = ↓ ↑ Made better by = Constant (24/7) = C Intermittent = I	**Pain** = electric shock, throbbing, sharp/stabbing, dull ache. Rate out of 10 please. **Sensation** = hypersensitivity, reduced/loss of sensation, touch or heat related