MS Therapy Centre Lothian

MS CLIENT REGISTRATION & SELF ASSESSMENT FORM

Full Name:									**Title:**			
Address:												
Town:							**Post Code:**					
Email:												
Contact Numbers:	**Home:**						**Mobile:**					
Date of Birth:		**SEX**	FEMALE		MALE		INTERSEX		MtF FEMALE		FtM MALE	
Your Household Are you currently Living with?	**Partner**	**Family**	**On own**		**Supported accommodation**		**Other (please detail)**					

Information About Your MS

MS Diagnosis:	**BMS**	**PPMS**	**RRMS**	**SPMS**	**Date of Diagnosis:**	

What symptoms are of concern (please √ appropriate box/es)?

FATIGUE		**SPEECH PROBLEMS**	
POSTURE & SEATING		**SWALLOWING PROBLEMS**	
VISION DISTRUBANCE		**SLEEP DISTURBANCE**	
BALANCE PROBLEMS		**POOR CIRCULATION**	
WEAKNESS IN ARMS		**PAIN**	
WEAKNESS IN LEGS		**SENSATION CHANGES**	
BLADDER PROBLEMS		**EMOTIONAL CHANGES**	
BOWEL PROBLEMS		**FOOT PROBLEMS**	

Medical Information

Medical Centre:				
Address:				
			Post Code:	
Main GP Seen:			**Tele:**	
MS Consultant			**Clinic:**	
Emergency Contact: *(Family/Friend)*	**Name:**		**Phone:**	
Relationship:				
Main Carer (if applicable)	**Name:**		**Phone:**	

Please provide details of ALL Prescribed Medications and/or Herbal Medications			
Medication	**Dosage**	**Medication**	**Dosage**

About You **Do you receive a CARE package?**												**Please √ if Not Applicable:**	
No:		**Yes (please give details)**		**Self Directed Support**		**Direct Payments**		**Local Autority**		**Private Care**			
Do you provide Care for someone?													
No		**Yes (please give details)**											
Do you receive any other health or social care services? E.g. District Nurse, Social Work, CPN, OT													
No		**Yes (please give details)**											
How did you hear about us?:		**GP/ Hospital**		**Internet Search**		**Friend/ Family**		**Other (specify)**					
Are you currently		**Employed**				**Retired**		**Unable to work**					
		Full time		**Part time**		**Receipt of DLA/PIP**							
						Receipt of Benefit							

Which MSTC Services/Therapies are you interested in? ***(Please tick appropriate box/es)***	**Information & Advice**	**MS Factsheets**		**Benefits/Finances**		**Housing**			
		Nutrition/Diet		**Support Services**		**Carers Support**			
		Self Directed Support		**MS Support Grants**		**Assessments**			
	Complementary Therapies	**Reflexology**		**Massage**		**Reiki**			
	Neurological Physiotherapy	**1:1 Physio**		**Group Classes**		**Acupuncture**			
	Adapted Exercise	**Pilates**				**Yoga**			
	Oxygen Treatment								
Do you use a walking/mobility aid?	**Yes**		**No**		**Details:**				

How do you travel to the Centre?									
Car		Public Transport		Taxi		Specialist mobility taxi/bus		Other (please specify)	

MS Evaluation (MSIS-29)

In the past two weeks, how much has your MS limited your ability to:	**Not at all**	**A little**	**Moderately**	**Quite a bit**	**Extremely**
1. Do physically demanding tasks?	**1**	**2**	**3**	**4**	**5**
2. Grip things tightly (e.g. turning on taps)?	**1**	**2**	**3**	**4**	**5**
3. Carry things?	**1**	**2**	**3**	**4**	**5**

In the past two weeks, how much have you been bothered by:	**1**	**2**	**3**	**4**	**5**
4. Problems with your balance?	**1**	**2**	**3**	**4**	**5**
5. Difficulties moving about indoors?	**1**	**2**	**3**	**4**	**5**
6. Being clumsy?	**1**	**2**	**3**	**4**	**5**
7. Stiffness?	**1**	**2**	**3**	**4**	**5**
8. Heavy arms and/or legs?	**1**	**2**	**3**	**4**	**5**
9. Tremor of your arms or legs?	**1**	**2**	**3**	**4**	**5**
10. Spasms in your limbs?	**1**	**2**	**3**	**4**	**5**
11. Your body not doing what you want it to do?	**1**	**2**	**3**	**4**	**5**
12. Having to depend on others to do things for you?	**1**	**2**	**3**	**4**	**5**
13. Limitations in your social and leisure activities at home?	**1**	**2**	**3**	**4**	**5**
14. Being stuck at home more than you would like to be?	**1**	**2**	**3**	**4**	**5**
15. Difficulties using your hands in everyday tasks?	**1**	**2**	**3**	**4**	**5**
16. Having to cut down the amount of time you spent on work or other daily activities?	**1**	**2**	**3**	**4**	**5**
17. Problems using transport (e.g. car, bus, train, taxi, etc.)?	**1**	**2**	**3**	**4**	**5**
18. Taking longer to do things?	**1**	**2**	**3**	**4**	**5**
19. Difficulty doing things spontaneously (e.g. going out on the spur of the moment)?	**1**	**2**	**3**	**4**	**5**
20. Needing to go to the toilet urgently?	**1**	**2**	**3**	**4**	**5**
21. Feeling unwell?	**1**	**2**	**3**	**4**	**5**
22. Problems sleeping?	**1**	**2**	**3**	**4**	**5**
23. Feeling mentally fatigued?	**1**	**2**	**3**	**4**	**5**
24. Worries related to your MS?	**1**	**2**	**3**	**4**	**5**
25. Feeling anxious or tense?	**1**	**2**	**3**	**4**	**5**
26. Feeling irritable, impatient, or short tempered?	**1**	**2**	**3**	**4**	**5**
27. Problems concentrating?	**1**	**2**	**3**	**4**	**5**
28. Lack of confidence?	**1**	**2**	**3**	**4**	**5**
29. Feeling depressed?	**1**	**2**	**3**	**4**	**5**

I wish to use the Oxygen Treatment Service (please tick) ☐

Oxygen Treatment Checklist	No	Yes	If yes, please give details including dates.
Have you been on any of the following medication? Doxorubicin (Adriamycin), Bleomycin, Disulfiram (Antabuse/Refusal), Cisplatinum, Mafenide Acetate (Sulfamylon), Levothyroxine, Fluoxetine.			
Are you currently on any of the following medication? Codeine, Hydrocodone, Ibuprofen, Oxycodone, Paracetamol, Tramadol or Zolpidem.			
Are you currently taking any **High Blood Pressure (Hypertension)** medication?			
a) Have you had a pneumothorax (collapsed lung)? b) Was it properly treated?			
Do you have emphysema?			
Have you ever had tuberculosis?			
Do you have Chronic Obstructive Pulmonary Disease?			
Have you ever had any other lung problems?			
Have you had any surgery in the last six months?			
a) Have you ever had a seizure? b) Was it induced by drugs or alcohol			
Do you have a cold, chest infection etc?			
Do you suffer from chronic sinusitis?			
Do you have a temperature or a fever?			
Do you have Otosclerosis (*bone growth of the middle ear*)?			
Have you ever had a rupture of the oval or round membrane of the inner ear?			
Do you have optic neuritis?			
Do you have glaucoma?			
Do you have congenital spherocytosis (auto-hemolytic anemia- disease of the blood)?			
Do you have a pacemaker or other medical devices?			
Are you pregnant?			
Do you suffer from any long term conditions? e.g. claustrophobia, diabetes, epilepsy,			
Are you or have you ever been a smoker?			
Are you currently taking a prescribed **Anticoagulant/ Bblood Thinner**? Such as, Warfarin; ivaroxaban (Xarelto); dabigatran (Pradaxa); apixaban (Eliquis); edoxaban (Lixiana)			

Oxygen Treatment Plan (Office Use Only)

Client Name:				Health Condition							
Introductory Session											
Date:		O2T Session details:		Pressure:		Time:		Booklet Received			
Number of Sessions to be completed:				Protocol Number:		Start Date:					
End Date:		Follow –up/Review Date:									
Treatment continuation (PTP):	Yes		No		Frequency:	Weekly:		Twice weekly:			

MSTC does not provide medical advice, diagnose health conditions or prescribe treatments. We base a client's access to, and engagement with oxygen treatment on a client's self-declared condition/s and prescribed medications. Access to, and appropriateness of treatment is based on assessment of client self - declared information and existing evidence and protocols within the field of hyperbaric medicine.

Client Consent

- I confirm my willingness to participate in Oxygen Treatment and other therapies as appropriate at the MS Therapy Centre.
- I will inform MS Therapy Centre staff of any changes to my medical condition or medications.
- I am aware that the therapy may not be beneficial to me and that it is not possible to know in advance if I will benefit.
- I hereby give my consent for my General Practitioner and/or other health and social care agencies to be contacted concerning my suitability for therapies and/or to obtain any necessary information that may be relevant.
- I also consent to me being transferred by patient transfer hoist or other recognised procedures as may be required on an emergency basis, but I confirm that I am aware that the Centre's policies require me to provide for physical or other assistance under normal circumstances.
- I give my permission for the MS Therapy Centre to keep a copy of the Assessment and other records on file.
- I confirm that I have received, read and will comply with the guidance, health & safety procedures and other information included in the : ***Oxygen Treatment Guidance & Information booklet, including Fire Instructions and Health & Safety procedures, and Cancellation Policy***
- I accept that if I do not follow MS Therapy Centre Lothian staff instructions I do so at my own risk, and MS Therapy Centre Lothian will not be held liable for any accidents that occur.
- I understand that the MS Therapy Centre Lothian is not part of the NHS and is a privately managed self-help charity that employs professional staff and trained volunteers and relies on contributions from clients and supporters in order for it to continue its work.
- The MS Therapy Centre Lothian may use my email address for information and notifications regarding the Charity's business

In accordance with the Data Protection Act 1998, all personal data supplied to MSTC Lothian (the data controller) will be held in the strictest confidence and will not be passed on to any third parties without your consent. Your personal data will only be used for the purposes of administering client services at the Centre. If you have any concerns regarding the way your personal information is stored or used by MSTC Lothian, you may contact Nancy Campbell on 0131 554 5384.

<table>
<tr><td colspan="3">Client Name:
Date:</td><td>Signature:</td></tr>
<tr><td colspan="4">FOR OFFICE USE ONLY</td></tr>
<tr><td colspan="3">Date Received:
Date: Reviewed:</td><td rowspan="2">Additional Information & Notes:</td></tr>
<tr><td colspan="3">Date GP Letter Sent:
Date GP Information Received:
Physiotherapy Referral:</td></tr>
<tr><td>O2T Suitability</td><td>YES</td><td>NO</td><td>Personal Therapy Plan</td></tr>
<tr><td colspan="3" rowspan="2">On behalf of MS Therapy Centre
Name:
Signature:
Date:</td><td></td></tr>
<tr><td>SO Details:</td></tr>
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