**Physiotherapy Self-Referral Form**

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| **Sources of information, advice and exercise:**<https://www.nhsinform.scot/> |
| **If your problem is urgent, severe, or getting worse, contact your GP or NHS24 (Phone 111)**If you have *any* of these symptoms, since this problem started, then you *must* consult your GP. |
| * Dizziness
* Blurred vision
* Swallowing problems
* Speech impairment
* History of cancer
 | * Fainting
* Bowel/bladder problems
* Reduced or altered sensation in your groin, genitals or back passage area
* Weakness in both legs
* Unexplained weight loss
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**Information and Instructions**

1. This form is to request a **ROUTINE** out-patients physiotherapy appointment only.

If you consider your problem to be urgent you must get a referral from your GP.

1. We can only accept referrals from patients who are registered with a GP Practice in **Edinburgh**

(If you are unsure please ask your GP practice)

1. You must be aged 16 or over to use the self referral service
2. Please refer yourself for **ONE** problem only

(We are not able to accept self referral for multiple, unrelated problems - please ask your GP)

1. We will inform your GP that you have attended physiotherapy

**Home visits** can only be arranged by your GP

**Continence problems and walking aids:** Please use the separate referral forms which can be found on our self-referral page: [Self-referral – Edinburgh Health & Social Care Partnership: Physiotherapy](https://services.nhslothian.scot/ecps/self-referral/)

**Equipment such as collars, wrist splints, knee braces, maternity belts etc** cannot be routinely provided

**Please post your completed form to:** Physiotherapy Department

Slateford Medical Centre

27 Gorgie Park Close

Edinburgh

EH14 1NQ

**Or, e-mail:** loth.physioselfrefedinnoreply@nhslothian.scot.nhs.uk

We will add your referral to the waiting list. When you reach the top of the waiting list we will send

you a letter asking you to call us to arrange an appointment. If your referral is not suitable for our service we will contact you to let you know.

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| Date of Birth:       | Today’s Date:       ***only adults over 16 can self refer*** |
| SURNAME:       | Tel 🕿 Home:       |
| FIRST NAME:      Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other:       | Tel Mob:      *(Please give a daytime number – we may contact you either by phone or post)* |
| Address:           Postcode:      GP Practice:       | Can we leave a voice message? Yes [ ]  No [ ] Is your GP aware of this problem? Yes [ ]  No [ ]  |

**When answering the questions below, please tick the box that applies to you the best:**

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| 1. Where is your main problem area? Neck [ ]  Neck with arm pain [ ]  Shoulder [ ]

Elbow [ ]  Wrist/hand [ ]  Lower Back [ ]  Lower back with leg pain [ ]  Hip/Groin [ ]  Knee [ ]  Foot/ankle [ ]  Other [ ]  Please specify:       |
| 1. Briefly describe your problem (eg: pain, weakness, numbness):
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| 1. How long have you had this problem? Less than 6 weeks [ ]  6-12 weeks [ ]

More than 12 weeks [ ]  If longer than 12 weeks, state how long:       |
| 1. Why did this problem start? Accident or injury [ ]  No reason [ ]  Gradual [ ]  Overuse [ ]
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| 1. Have you had this problem before? Yes [ ]  No [ ]
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| 1. Is this problem? Improving [ ]  Not changing [ ]  Worsening [ ]
 |
| 1. Is this problem disturbing your sleep? No [ ]  Yes [ ]  If yes, how often?
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| 1. Are you off work because of this problem? No [ ]  Yes [ ]  If yes, how long for?
 |
| 1. Are you unable to care for someone because of this problem? No [ ]  Yes [ ]
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| 1. Please tell us if you have any difficulty speaking English or require an interpreter (if ‘yes’ which language) or if you have any other needs, eg: visual or hearing impairment:

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| 1. Please tell us the name of any medications you are currently taking:
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