

Physiotherapy Self-Referral Form

Sources of information, advice and exercise:

<https://www.nhsinform.scot/>

www.ecps.scot.nhs.uk

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

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.
2. 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)
3. You must be aged 16 or over to use the self referral service
4. Please refer yourself for **ONE** problem only
(We are not able to accept self referral for multiple, unrelated problems - please ask your GP)
5. 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: <https://services.nhslothian.scot/ecps/Pages/SelfReferral.aspx>

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.

Date of Birth:	Today's Date: <i>only adults over 16 can self refer</i>
SURNAME:	Tel 📞 Home:
FIRST NAME:	Tel Mob: <i>(Please give a daytime number – we may contact you either by phone or post)</i>
Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other:	
Address:	Can we leave a voice message? Yes <input type="checkbox"/> No <input type="checkbox"/>
Postcode:	
GP Practice:	Is your GP aware of this problem? Yes <input type="checkbox"/> No <input type="checkbox"/>

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

1. Where is your main problem area? Neck <input type="checkbox"/> Neck with arm pain <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Lower Back <input type="checkbox"/> Lower back with leg pain <input type="checkbox"/> Hip/Groin <input type="checkbox"/> Knee <input type="checkbox"/> Foot/ankle <input type="checkbox"/> Other <input type="checkbox"/> Please specify:
2. Briefly describe your problem (eg: pain, weakness, numbness):
3. How long have you had this problem? Less than 6 weeks <input type="checkbox"/> 6-12 weeks <input type="checkbox"/> More than 12 weeks <input type="checkbox"/> If longer than 12 weeks, state how long:
4. Why did this problem start? Accident or injury <input type="checkbox"/> No reason <input type="checkbox"/> Gradual <input type="checkbox"/> Overuse <input type="checkbox"/>
5. Have you had this problem before? Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Is this problem? Improving <input type="checkbox"/> Not changing <input type="checkbox"/> Worsening <input type="checkbox"/>
7. Is this problem disturbing your sleep? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, how often?
8. Are you off work because of this problem? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, how long for?
9. Are you unable to care for someone because of this problem? No <input type="checkbox"/> Yes <input type="checkbox"/>
10. 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:
11. Please tell us the name of any medications you are currently taking: