# Physiotherapy Self-Referral Form

**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

## 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: Self-referral – Edinburgh Health & Social Care Partnership: Physiotherapy

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

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

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