**Physiotherapy Self-Referral Form**

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| **Sources of information, advice and exercise:**  <https://www.nhsinform.scot/>  [www.ecps.scot.nhs.uk](http://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.

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: <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](mailto: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): |
| 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 |
| 1. Have you had this problem before? Yes  No |
| 1. Is this problem? Improving  Not changing  Worsening |
| 1. Is this problem disturbing your sleep? No  Yes  If yes, how often? |
| 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 |
| 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: |
| 1. Please tell us the name of any medications you are currently taking: |