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

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.

Today's Date:	Date of Birth: ***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:

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:
2. Briefly describe your problem (eg: pain, weakness, numbness):
3. 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:
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: