Physiotherapy Self-referral Form

For over 12s and adults

This form allows you to refer directly for physiotherapy without seeing your GP. If your details are incomplete this will delay your appointment.

If you need this form in an alternative format contact the Physiotherapy Department on 01595 74 3323

If you require urgent attention please seek medical advice, e.g. your GP or NHS 24 (Tel 08454 242424).

Full name: _____ **Known as:** _____

Address: _____

_____

_____ **Postcode:** _____

Contact Numbers - **Date of Birth:** _____

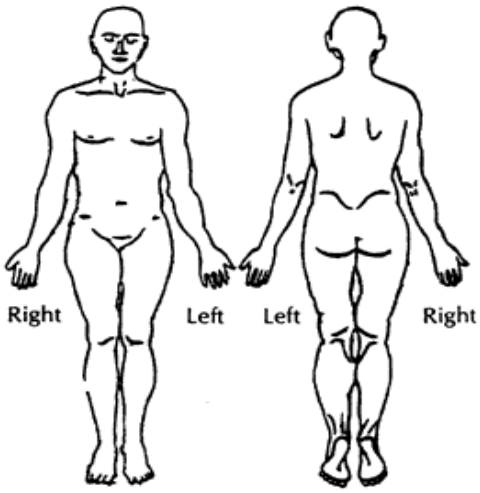
Home: _____

Work: _____ **Registered Health Centre:**

Mobile: _____ _____

Describe your current problem and symptoms or give details if you are requesting a review/provision of a walking aid:

Please mark on any pain, pins and needles or numbness you have related to this problem:



If you answer yes to either of the following two questions, fill in the shaded box below.

- Are you referring with back pain? Yes ☐ No ☐
- Are you referring with back **and** leg pain? Yes ☐ No ☐

Have you **recently** developed any of the following symptoms with **this** episode of back pain?

- New or unexpected difficulty passing urine or controlling bladder/bowels Yes☐ No☐
- Numbness around back passage or genitals Yes☐ No☐
- New or worsening numbness, pins and needles or weakness in **both** legs Yes☐ No☐
- New and unexplained unsteadiness on your feet Yes☐ No☐

If you have answered yes to any of the above, we may contact you to clarify symptoms

Continued overleaf →

1. How long have you had this problem?

2. Since it began, is it: Improving ☐ The same ☐ Worsening ☐ Variable ☐

3. Is the problem: New ☐ Longstanding ☐ Recurrent ☐

4. Have you seen your GP/another healthcare practitioner/physiotherapy in the past about this problem? Yes ☐ No ☐

If Yes, please give details (e.g. by who, what was the outcome?)

5. Are you off work/school or unable to care for a dependant because of this problem?

Yes ☐ Long term incapacity ☐
No ☐ Not applicable ☐

6. If school age, are you able to participate fully in PE?

Yes ☐ No ☐

7. Is this problem affecting your ability to sleep?

Woken from sleeping ☐ Unable to sleep at all ☐ No ☐

Past Medical History:

8. Please list all conditions that you have been diagnosed with or any operations/illnesses that you have had:

9. Have you ever been diagnosed with cancer? Yes☐ No☐ Please give details in box:

10. Please list all current medications (prescribed and over the counter):

11. Are you housebound due to a medical condition? Yes ☐ No ☐

12. How many falls have you had this past year?

Tick the box to confirm the information you have provided can be shared with your GP ☐
I consent to Physiotherapy accessing my medical information if required ☐

Parent/guardian name and signature for under 16's: _____
Under 16's must be accompanied by parent/guardian

Return to: **Physiotherapy Department, Gilbert Bain Hospital, Lerwick, Shetland, ZE1 0TB**