East Lothian Health and Social Care Partnership
East Lothian Community Hospital
Alderston Road | Haddington | EH41 3PF
eastlothian.gov.uk/elhscp

Physiotherapy Self-Referral Form

Sources of information, advice and exercise:

https://www.nhsinform.scot/

Rehabilitation Service | East Lothian Council

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 an out-patients physiotherapy appointment only.

2. We can only accept referrals from patients who are residents of East Lothian and pay their council tax to East Lothian Council.

3. You must be aged 16 or over to use the self-referral service.

4. We will inform your GP that you have attended physiotherapy.

Equipment such as collars, wrist splints, knee braces, maternity belts etc are not available to be provided.

Please post your completed form to:
Physiotherapy – South Office
East Lothian Community Hospital
Alderston Road
Haddington
EH41 3PF

Or e-mail: loth.physioselfrefelrsnoreply@nhs.scot

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.

Physiotherapy Self-Referral Form

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

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 ☐

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:
11. Please tell us your relevant Past Medical History:
12. Please tell us the name of any medications you are currently taking:

PLEASE e-mail the completed referral form to: loth.physioselfrefelrsnoreply@nhs.scot