

**Physiotherapy Services**

- Boston House, Wigan Health Centre, Frog Lane, Wigan, WN6 7LB, TEL: (01942) 482260
- Platt Bridge Health Centre, Rivington Ave, Platt Bridge, Wigan, WN2 5NG, TEL: (01942) 482403
- Leigh Health Centre, Leigh Infirmary, The Avenue, Leigh, WN7 1HR, TEL: (01942) 483413

As a patient of this GP practice, you can refer yourself for physiotherapy without visiting your GP first by filling in the form below.

**Please note: If you have any of the following, please see your GP before referring yourself:**

- Changes in your bladder and bowel habits.
- A hot swollen joint.
- Constant severe pain and you are unable to find relief.
- Weakness, pins and needles, loss of feeling.
- History of cancer

**GUIDANCE**

Fill in all the boxes and return the bottom section to the Reception Desk at nearest Physiotherapy Department listed above.

**Who is eligible?**

- Anyone over 16 years old that is a patient of this GP practice who has pain or discomfort in their muscles, joints or ligaments.



**Cut along dotted line** -----

<b>YOUR DETAILS</b>	
Name: .....	Gender: .....
Address: .....	Tel No. Home: .....
.....	Mobile: .....
Postcode: .....	GP Practice: .....
Date of birth* ...../...../.....	
<b>Where on your body is your problem?</b>	<b>How long have you had this problem for?</b>
<b>What are your main symptoms?</b> (For example pain/ aching/ stiffness/ swelling)	<b>Please add any other details that you think we need to be aware of.</b>

**What happens once the form has been received by us?**

- Your referral form will be looked at by a Physiotherapist and we will decide whether we can help with your condition.
- When we are in a position to offer you an appointment, we will contact you.

**Whilst awaiting your appointment, helpful advice can be found at**

- [www.nhs.choices.co.uk](http://www.nhs.choices.co.uk)
- [www.arthritisresearchuk.org](http://www.arthritisresearchuk.org)

**If your condition changes please contact us for advice.**

**Declaration**

As part of providing you with direct care, the Trust may have to share your information with other partner organisations. To find out more information about this, please refer to the Trust's Privacy Policy.

By submitting this form, I agree to the Trust contacting me using the details given above. I understand that the Trust will:

- Securely store the information relating to my referral (and subsequent care, where applicable) in paper and/or electronic format,
- Keep the records for as long as required in the Records Management Code of Practice for Health and Social Care 2016 (or for longer if it is appropriate), and
- Confidentially destroy records when necessary



**Cut along dotted line** -----

<b>Are you the main carer for someone?</b> Yes/No	<b>Are you off work because of your problem?</b> Yes / No
<b>Do you consider yourself to have a disability?</b> Yes/ No	<b>Do you require an interpreter?</b> Yes/ No
<b>What type of disability do you have?</b>	<b>If yes, which language do you require?</b>

Signed (your signature).....

Date.....