NHS Borders

Self Referral to Physiotherapy – IN CONFIDENCE

Please fill out both sides of this form as fully as you can.

Date:.....

Section 1: Your Details

Name:..... DOB: .....

Address: .....

..... Post Code:.....

Day time contact number:..... Consultant .....

GP Name & Health Centre: .....

Do we have your permission to contact your GP? ❒Yes ❒No

Section 2: Reasons for referring

1. Do you have a diagnosis for your condition? ……

2. Please describe briefly why you are seeking Physiotherapy assessment (e.g. reduced mobility).....

.....

3. How long have you noticed these changes? .....

4. Have you had this or a similar problem before ❒Yes ❒No

If Yes, did you receive physiotherapy ❒Yes ❒No

If Yes, what treatment did you receive? ……..

5. Is your current difficulty the result of an accident or incident e.g. fall ❒Yes ❒No

If yes when .....

6. Do you use any walking aids? ❒Yes ❒No

If Yes, please specify ……

7. Do you use a wheelchair? ❒ All the Time ❒ Occasionally ❒Never

8. Is there a change in your ability to perform your normal daily activities? ❒Yes ❒No

Please give details: .....

.....

9. Are you at work at the moment? ❒Not applicable ❒Yes ❒No ❒ With Difficulty

10. Have you had a recent hospital admission? ❒Yes ❒No

If yes and this was related to your condition, please specify why?

……

PTO and complete page 2

11. Have you had any recent Investigations? ❒Yes ❒No

E.g. X-ray; MRI; Blood Test - If yes, could you provide brief details and results if known.....

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12. Please list any medications you are taking at the moment

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Section 3:– Have you experienced recent change in any of the following:-

1. Muscle weakness…….. ❒Yes ❒No
2. Vision e.g. blurred or double vision ……❒Yes ❒No
3. Tripping/stumbling/falls ……❒Yes ❒No
4. Balance /mobility …….. ❒Yes ❒No
5. Swallowing or choking …… ❒Yes ❒No
6. Tone e.g. spasms, muscle stiffness ……..❒Yes ❒No
7. Dizziness…… ❒Yes ❒No
8. Sensation e.g. numbness, pins & needles…… ❒Yes ❒No
9. Pain level…… ❒Yes ❒No

Height …… Weight ……

Any other information you think we should know ……..

……

……

If you find your symptoms get worse while you wait for an appointment you are advised to see your GP.

Signature:..... Date: .....

If someone is completing this form on your behalf, please ask them to fill in below:

Name…… Relationship to Referral applicant……

Please return your completed self-referral form to the receptionist at your GP practice or your local Physiotherapy Department

For office use only:

Clinical Exception Routine Yellow Red Suitable for student Y/N

Date Received		Letter to GP	
CHI No.		Recorded on Epex	
Appointment Date		Discharge Date	