9. Past Medical History

| | Yes | No |
|---|---|---|
| Unexplained weight loss | ☐ | ☐ |
| Anti-coagulants/blood clots | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Surgeries/injuries (in the past year) | ☐ | ☐ |
| History of cancer | ☐ | ☐ |
| Any possibility you are pregnant<br>*(Please bring along your pregnancy pack if you are)* | ☐ | ☐ |

10. Please list your current medication below:

☐ Please tick the box to confirm that the information you have provided is accurate and can be shared with your GP.

## Please return your completed form to:

Lewis & Harris: Red Postbox, Reception, Western Isles Hospital, Macaulay Road, Stornoway, Isle of Lewis, HS1 2AF.

Uists & Barra: Physiotherapy Department, Uist and Barra Hospital, Balivanich, Benbecula, HS7 5LA.

## Further help and information

Physiotherapy Department, Western Isles Hospital, MacAulay Road, Stornoway, Isle of Lewis, HS1 2AF. Telephone 01851708258

## We are listening - how did we do?

We welcome your feedback, as it helps us evaluate the services we provide. If you would like to tell us about your experience:

- speak to a member of staff
- visit our website www.wihb.scot.nhs.uk/feedback or share your story at - www.patientopinion.org.uk or 0800 122 31 35
- Tel. 01851 704704 (ext 2408) on a Tuesday and Friday afternoon between 1pm and 4pm.

Version: 1.2 Review Date: October 2016 Produced by: Physiotherapy Dept, WIH.

**Disclaimer**

The content of this leaflet is intended to augment, not replace, information provided by your clinician. It is not intended nor implied to be a substitute for professional medical advice. Reading this information does not create or replace a doctor-patient relationship or consultation. If required, please contact your doctor or other health care provider to assist you interpret any of this information, or in applying the information to your individual needs.



Bòrd SSN nan Eilean Siar
NHS Western Isles

NHS Eileanan Siar Western Isles

# Physiotherapy Department

## Self-Referral Form


This form allows you to refer yourself directly for physiotherapy without seeing your GP. Please fill out this form correctly as it allows us to allocate you an appropriate appointment.

Self Referral is not appropriate for people under the age of 16, Respiratory, Gynaecological or Neurological conditions. Please see your GP in the first instance if you have any concerns.

### What will happen next?

- This referral form will be checked by a physiotherapist.
- If we think that we can help your condition we will place you on a waiting list.
- You will be contacted by a letter or telephone to arrange an appointment.

### How long will I have to wait?

- This depends on the current physiotherapy waiting list.
- Please be aware that at times of high demand you may have to wait longer.

**If your problem requires urgent attention, is severe or is worsening, please seek more urgent medical attention by telephoning your GP, or freephone NHS 24, tel. 111.**

**Date:** ……/……/……..

**Name:** ……

**Date of Birth:** ……/……/……..

**Address:** ……

……

……

**Postcode:** ……

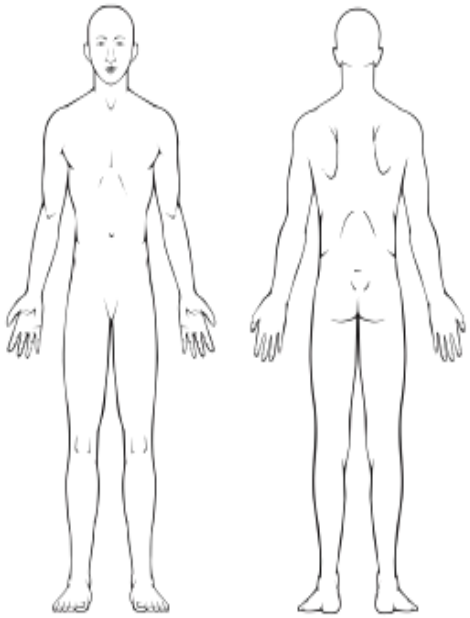
**Occupation:** ……

**Contact Numbers:**

Home ……..…… Work ……..…… Mobile ……..……

**GP Practice:** ……

Please mark on the diagram below the location of your problem.



Please describe your current problems and symptoms below.

1. Using the scale of 0-10 below, circle where your average level of pain is, where 0 is no pain and 10 is the worst possible pain.

0 1 2 3 4 5 6 7 8 9 10

**Please answer the following:**

2. How long have you had this problem? ……

3. Since it began is the problem:

☐ Improving ☐ The Same ☐ Worsening ☐ Varying

4. Is the problem:

☐ New ☐ Longstanding ☐ Recurring

5. Have you recently developed any of the following symptoms?

| | Yes | No |
|---|---|---|
| Difficulty passing urine or controlling bladder / bowels | ☐ | ☐ |
| Numbness around your back passage or genitals | ☐ | ☐ |
| Numbness, pins and needles or weakness in both legs | ☐ | ☐ |
| Unsteadiness on your feet | ☐ | ☐ |

6. Have you seen a GP or other healthcare worker/ physiotherapist for this problem? Yes ☐ No ☐

*If yes, please provide details below.*

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

☐ Yes ☐ Long term incapacity ☐ No ☐ N/A

8. Is this problem affecting your ability to sleep? Yes ☐ No ☐