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.
Alternatively, you can return your completed form via email to: wi.physio@nhs.scot

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.
- Once you reach the top of the waiting list, you will be contacted by a letter or telephone to arrange an appointment.

If we believe your needs would be better met by a different service we will contact you to let you know.

How long will I have to wait?

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

Further help and information

- Information to help you manage your condition is available at NHS inform at: **www.nhsinform.scot/msk**
- Physiotherapy Department, Western Isles Hospital, MacAulay Road, Stornoway, Isle of Lewis, HS1 2AF. Telephone 01851 708258 or email: wi.physio@nhs.scot

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.careopinion.org.uk or tel. 0800 122 135
- tel. 01851 704704 (ext 2236) Monday-Friday between 10am-4pm.

Version: 6.1 Review Date: June 2026 Produced by: Physiotherapy Dept, WIH.

NHS Eileanan Siar Western Isles

Patient Completed Self-Referral Form

Physiotherapy Department

This form allows you to refer **yourself** directly for physiotherapy without seeing your GP.

Please fill out this form in full as it allows us to allocate you an appropriate appointment. This form is not to be completed on someone else's behalf and health professionals are asked to use the appropriate referral pathways.

Self Referral is not appropriate for people under the age of 16 or for addressing Respiratory, Gynaecological or Neurological conditions. Please see your GP in these instances.

We are also **unable to accept a self-referral if your condition is due to a fractured or broken bone** within the past 3 months **or if you have had surgery for this condition** within the past 3 months – we need a referral from your hospital clinic to make sure physiotherapy is appropriate.

Please inform your GP of this referral if you:

- have recently become unsteady on your feet
- are feeling generally unwell/fever
- have a history of cancer
- have any unexplained weight loss.

If you have recently or suddenly developed any of the following symptoms please seek help immediately from either your GP (emergency appointment), NHS24 (tel. 111) or at your local Emergency Department:

- difficulty passing urine or controlling bladder/bowels
- numbness or tingling around your back passage or genitals
- numbness, pins and needles or weakness in **both** legs.

Date: ……/……/……..

Name: ……

Date of Birth: ……/……/…….. **Preferred Pronoun:** .....

Address: ……

……

……

Postcode: ……

Email: ……

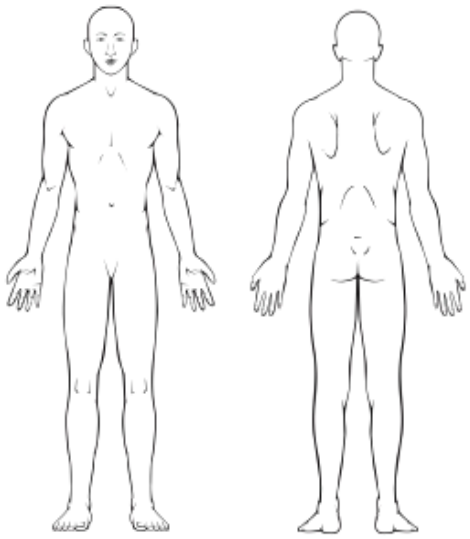
Occupation: ……

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.

Please answer the following:

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

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

3. Since it began is the problem:

☐ Improving ☐ The Same ☐ Worsening ☐ Varying

4. Is your problem due to a recent injury or fall? ☐ Yes ☐ No

5. Is the problem:

☐ New ☐ Longstanding ☐ Recurring

6. Have you seen a Physiotherapist, GP or other healthcare worker for this problem before? *If yes, please provide details below.* ☐ Yes ☐ No

7. Are your daily activities affected by your problem?

☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely

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

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

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

10. Please list your current medication below:

I confirm the information I have provided is accurate and can be shared with my GP.

Patient signature: .....