**SELF REFERRAL TO PHYSIOTHERAPY**

To refer yourself to physiotherapy either complete and sign this form and send it to us at your preferred location **OR** contact us on the relevant telephone number as detailed at the end of the form.

Name GP’s Name

Address GP’s Surgery   
 Address

**HEFT staff members please tick**

Can we leave a message?

Phone no. (home) Yes No

Phone no. (work) Yes No

Phone no. (mobile) Yes No

Date of Birth Today’s date

Please note no under 18’s accepted

Do you require an interpreter? Yes No

If yes, which language?

Please give a brief description of why you would like a physiotherapy assessment:   
(please note only one condition can be assessed)

**THE FOLLOWING CONDITIONS REQUIRE A GP REFERRAL AND WILL NOT BE ACCEPTED AS A SELF REFERRAL**  
All Neurological Conditions All Respiratory Conditions  
All Incontinence/Gynaecological Problems Anyone under the age of 18  
All patients requiring a home visit All pregnancy related conditions

**PTO**

How long have you had this complaint? (Please tick)

Less than 6 weeks More than 6 Weeks

Is the problem New On-going

Are the symptoms worsening? Yes No

**Please tick if you are currently affected by any of the following:**

**IMPORTANT INFORMATION (MANDATORY)**

|  |  |  |  |
| --- | --- | --- | --- |
| Unexplained weight loss |  | Unexplained bladder or bowel problems |  |
| History of cancer |  | Night pain |  |
| Fever or night sweats |  | Unsteady on feet |  |
| Pins and needles or numbness in both arms or legs |  | Altered sensation in genital region |  |

It may be necessary for you to get undressed so please wear appropriate clothing and underwear or bring shorts with you, so that we can see the part of the body that requires assessment and treatment.

It may be necessary for us to communicate with your Doctor after this appointment, either to provide us with information to support our assessment, or to provide your Doctor with information about how we have treated you. If you are happy to consent please sign below.

*For staff only: Patient verbally consented to telephone referral. Date: Time:*

**Patient Signature: …………………………….. …….. Date: ……………..………………….**

Please either ring the relevant contact number as outlined below, or fax/post your referral to the correct address. We will contact you to arrange a mutually agreed appointment once the referral has been processed.

**1. Physiotherapy Appointments in Solihull Community**

**CONTACT CENTRAL BOOKING on 0121 329 0107**

**FAX: 0121 329 0198**

**POST: Physiotherapy Department, Chelmsley Wood Primary Care Centre, Crabtree Drive, Chelmsley Wood B37 5BU**

**Please tick the box for your preferred choice of location for physiotherapy:**

• Balsall Common Health Centre

• Chelmsley Wood Primary Care Centre

• Freshfields Health Centre – Knowle

• Hobs Moat Medical Centre – Solihull

• Hurst Lane Clinic – Castle Bromwich

• Northbrook Health Centre – Shirley

• Shirley Clinic

**2.Physiotherapy Appointments in the Acute Hospitals**

If you live closer to one of the acute hospitals listed below and it is easier to have your treatment there then please contact

**POST: Solihull Hospital Physiotherapy Department, Lode Lane, Solihull B91 2JL**

**Telephone: 0121 424 5446**

**POST: Good Hope Hospital Physiotherapy Department, Rectory Road, Sutton Coldfield, B72 7RR**

**Telephone: 0121 424 9053**

**POST: Heartlands Hospital Physiotherapy Department, Bordesley Green East, Birmingham, B9 5SS**

**Telephone: 0121 424 0493**

**If you are uncertain about whether you can self-refer or not please contact your local clinic for advice.**