

Children and Young People's Physiotherapy Service - Self Referral



We accept all children and young people under the age of 18 and in school.

Please complete all parts of this form and send to the appropriate area:

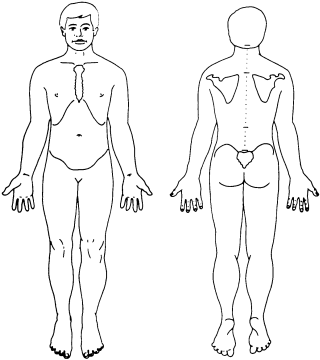
**Queen Margaret Hospital**  
**Whitefield Road**  
**DUNFERMLINE**  
**KY12 0SU**

**Adamson Hospital**  
**Bank Street**  
**CUPAR**  
**KY15 4JG**

**Randolph Wemyss Hospital**  
**BUCKHAVEN**  
**KY81HU**

OR email it to: **Fife-UHB.PaedsPhysioReferrals@nhs.net**

Please note: we are unable to process referrals without the information requested in **BOLD**. All referrals will be triaged and you may be offered an appointment.

|   |      |   |
|---|------|---|
| <b>Date:</b>  |      | Self Referral <input type="checkbox"/> GP Suggested <input type="checkbox"/>  |
| <b>Name:</b>  |      | Male <input type="checkbox"/> Female <input type="checkbox"/>   |
| <b>Date of Birth/CHI:</b>   |      | Name of Parent(s):  |
| <b>Address:</b>   |      | Parent's address (if different):  |
| <b>Post Code:</b>   |      | Would you like to receive appointment reminders by text?<br>Yes / No  |
| <b>Telephone:</b>   | Home | <b>Mobile</b>   |
| <b>GP Name:</b>   |      | <b>GP address:</b>  |
| Do you have any special requirements? (e.g. interpreter) Yes / No<br>Please describe:   |      |   |
| <b>Please complete for your main problem only</b>   |      |   |
|    |      | Please describe your current problem and symptoms below, <b>indicating whether you have been given any crutches/brace/moon boot?</b><br>.....<br>.....<br>.....<br>.....<br><br>How is it affecting your life? What are you unable to do now?<br>.....<br>.....<br>.....<br>.....<br>Please mark on the diagram the location of your main problem |
| <b>Tick one box only for each question</b>  |      |   |
| How long have you had your current problem? (Please state how long if more than 12 weeks)   |      |   |
| Less than 2 weeks <input type="checkbox"/> 2-6 weeks <input type="checkbox"/> 7-12 weeks <input type="checkbox"/> More than 12 weeks <input type="checkbox"/> _____ How long? |      |   |
| Is your problem getting? Better <input type="checkbox"/> Worse <input type="checkbox"/> Not changing <input type="checkbox"/>   |      |   |
| If in pain, how would you describe it? Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Do you have night Pain? Yes/No         |      |   |
| Are you off school because of this problem? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for how long:  |      |   |
| Are you taking any medication for this problem e.g. painkillers, anti-inflammatories?   |      |   |