

## SELF REFERRAL TO PHYSIOTHERAPY FOR MUSCULOSKELETAL ISSUES, such as:

- Back or Neck Pain
- Recent Strain or Sprain
- Joint or Muscle Pain

You can refer yourself directly to Physiotherapy without seeing your GP  
(Provided you are registered with a local authorising G.P practice)

***Referrals for respiratory conditions or women's/men's health conditions  
and for anyone under 16 years of age have to be referred by a GP.***

### **HOW TO ARRANGE A PHYSIOTHERAPY APPOINTMENT:**

1. Complete the attached self-referral form fully – (Please note you can only self-refer for one complaint)
2. Send the referral to the Physiotherapy Booking Centre via post, email or hand delivery to:

**Physiotherapy Booking Centre, Warwick Hospital, Lakin Road, Warwick, CV34 5BW**

**Email:** [therapies@swift.nhs.uk](mailto:therapies@swift.nhs.uk)

**Please note at some sites your first appointment may be in a class setting**

3. Approx. five working days after the Physiotherapy Booking Centre has received your referral form please telephone **01926 608068** to book your appointment (Please note: the booking centre co-ordinates appointments for all South Warwickshire's NHS Physiotherapy Clinics)
4. **If we do not hear from you this paper form will be securely destroyed four weeks after the date it was received and the referral will be closed.**

### **What can I do to help myself in the meantime?**

Research has shown that resting for more than a day or two does not help and may prolong pain and disability. However you may need to modify your activities initially.

Changing your position or activity frequently throughout the day will help prevent and reduce stiffness.

Over the counter painkillers can be helpful. A pharmacist will be able to advise you on the appropriate tablets.

**NOTE: WE ARE UNABLE TO ACCEPT REFERRALS OVER THE PHONE AND WE CANNOT BOOK  
YOU AN APPOINTMENT UNTIL WE HAVE RECEIVED YOUR REFERRAL FORM**

When you attend please ensure you wear suitable clothing/footwear to enable your problem area to be assessed appropriately



## SELF REFERRAL FOR PHYSIOTHERAPY

### I WOULD PREFER TO BE SEEN AT:

- |  |  |   |
|--|--|---|
| <input type="radio"/> WARWICK HOSPITAL<br><input type="radio"/> LEAMINGTON REHAB HOSPITAL<br><input type="radio"/> STRATFORD UPON AVON HOSPITAL<br><input type="radio"/> SOUTHAM CLINIC<br><input type="radio"/> KINETON SURGERY | <input type="radio"/> HENLEY MEDICAL CENTRE<br><input type="radio"/> KENILWORTH CLINIC<br><input type="radio"/> ELLEN BADGER HOSPITAL<br><input type="radio"/> ALCESTER PRIMARY CARE CENTRE<br><input type="radio"/> BIDFORD ON AVON HEALTH CENTRE | <input type="radio"/> MEON MEDICAL CENTRE<br><input type="radio"/> POOL MEDICAL CENTRE, STUDLEY<br><input type="radio"/> HOSPITAL OF ST. CROSS, RUGBY<br><input type="radio"/> RUGBY GP CLINICS:<br>_____ |
|--|--|---|

NAME:

MALE / FEMALE:

ADDRESS:

NHS NUMBER:

DATE OF BIRTH:

TELEPHONE NUMBERS: HOME: \_\_\_\_\_  
MOBILE: \_\_\_\_\_

Can we leave a message? Yes / No

DID YOUR GP SUGGEST SELF REFERRAL? YES / NO  
IF YES, PLEASE STATE WHICH G.P:

GP PRACTICE:

IS AN INTERPRETER REQUIRED? YES/NO

Sign or verbal language.

Which language? \_\_\_\_\_

**PLEASE COMPLETE ALL THE FOLLOWING INFORMATION: *Only one problem per referral please***

***Reason for Referral*** ( please give as much relevant information as possible)

**If you have back pain and experience any sudden changes to your bladder and bowel habits please seek emergency medical advice**

How long have you had this problem for? 0-4 Weeks / 5 – 16 Weeks / Greater than 16 Weeks

Is your problem: New / On-going / Previously treated by physiotherapy

Are you off work because of this problem? Yes / No

Are you a main carer for someone? Yes / No

Do you have any pins and needles associated with this problem? Yes / No

If Yes, where are they felt? \_\_\_\_\_

If you are prescribed medication please list below:

*If possible please bring your prescription in with you.*

**PLEASE TELEPHONE THE THERAPIES CALL CENTRE ON 01926 608068 TO BOOK YOUR APPOINTMENT  
5 working days AFTER DELIVERING THIS FORM TO ONE OF OUR DEPARTMENTS.**

***If we do not hear from you this paper form will be securely destroyed four weeks after the date it was received and the referral will be closed.***

PLEASE SEND REFERRAL TO: Email: [therapies@swft.nhs.uk](mailto:therapies@swft.nhs.uk)

Post: Therapies Department, Warwick Hospital, Lakin Road, Warwick, CV34 5BW