Children and Young People's Physiotherapy Service - Self Referral

Fife Health & Social Care Partnership
Supporting the people of Fife together

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

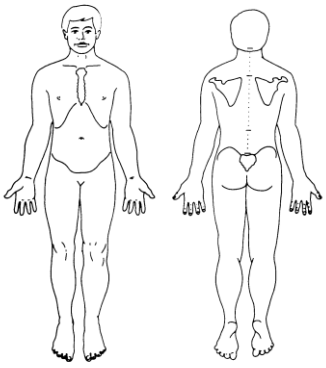
Randolph Wemyss Hospital
BUCKHAVEN
KY81HU

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.

Date:		Self Referral ☐ GP Suggested ☐
Name:		Male ☐ Female ☐
Date of Birth/CHI:		Name of Parent(s)**:**
Address:		Parent's address (if different):
Post Code:		Would you like to receive appointment reminders by text? Yes / No
Telephone:	**Home**	**Mobile**
GP Name:		**GP address:**

Do you have any special requirements? (e.g. interpreter) Yes / No
Please describe:

Please complete for your main problem only



Please describe your current problem and symptoms below**, indicating whether you have been given any crutches/brace/ moon boot?**

……
……
……
……

How is it affecting your life? What are you unable to do now?

……
……
……..

Please mark on the diagram the location of your main problem

Tick one box only for each question

How long have you had your current problem? (Please state how long if more than 12 weeks)
Less than 2 weeks ☐ 2-6 weeks ☐ 7-12 weeks ☐ More than 12 weeks ☐ _____ How long?

Is your problem getting? Better ☐ Worse ☐ Not changing ☐

If in pain, how would you describe it? Mild ☐ Moderate ☐ Severe ☐ Do you have night Pain? Yes/No

Are you off school because of this problem? Yes ☐ No ☐ If yes, for how long:

Are you taking any medication for this problem e.g. painkillers, anti-inflammatories?