Wrightington, Wigan and Leigh NHS Foundation Trust

ADULT MSK PHYSIOTHERAPY SELF-REFERRAL

You can refer yourself for physiotherapy without visiting your GP first by filling in the form below.

Please note: If you have any of the following, please see your GP before referring yourself:

- Changes in your bladder and bowel habits.
- A hot swollen joint.
- Constant severe pain and you are unable to find relief.
- Weakness, pins and needles, loss of feeling.
- History of cancer

Fill in all the boxes on the second page and either post, email or hand deliver that page to one of the Physiotherapy Departments listed below

Physiotherapy Departments

- **Boston House, Wigan Health Centre, Frog Lane, Wigan, WN6 7LB, TEL: (01942) 482260**
  ALWCH.mskphysio-bostonhouse@nhs.net

- **Platt Bridge Health Centre, Rivington Ave, Platt Bridge, Wigan, WN2 5NG, TEL: (01942) 482403**
  ALWCH.mskphysio-bostonhouse@nhs.net

- **Leigh Health Centre, The Avenue, Leigh, WN7 1HR, TEL: (01942) 483413**
  ALWCH.LeighPhysio@nhs.net

Please note these email addresses are for referrals only. Please do not use the email to contact department for any other purpose. Unless an email is encrypted the security of that email cannot be guaranteed.

Who is eligible?

- Anyone **over 16 years old** who has pain or discomfort in their muscles, joints or ligaments. You must be able to attend one of our outpatient departments; this form is not for patients who require a home visit.

What happens once the form has been received by us?

- Your referral form will be looked at by a Physiotherapist and we will decide whether we can help with your condition.
- When we are in a position to offer you an appointment, we will contact you.

Whilst awaiting your appointment, helpful advice can be found at

- **www.nhs.choices.co.uk**
- **www.arthritisresearchuk.org**

If your condition changes after submitting your self-referral, please contact us for advice.

Declaration

As part of providing you with direct care, the Trust may have to share your information with other partner organisations. To find out more information about this, please refer to the Trust's Privacy Policy.

By submitting this form, I agree to the Trust contacting me using the details given above. I understand that the Trust will:

- Securely store the information relating to my referral (and subsequent care, where applicable) in paper and/or electronic format,
- Keep the records for as long as required in the Records Management Code of Practice for Health and Social Care 2016 (or for longer if it is appropriate), and
- Confidentially destroy records when necessary

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Name: ……..…… Address: …….. ……..……...……..…… Postcode: ..…… Date of birth ……../……...../……..... NHS number (if known) ……	Gender: …….. Tel No. Home: ……..…….. Mobile: …… GP Practice: ……
Where on your body is your problem?	**How long have you had this problem for?**
What are your main symptoms? (For example pain/ aching/ stiffness/ swelling)	**Please add any other details that you think we need to be aware of.**

Are you a registered carer for someone? Yes/No	**Are you off work because of your problem?** Yes / No
Do you consider yourself to have a disability? Yes/ No **What type of disability do you have?**	**Do you require an interpreter?** Yes/ No **If yes, which language do you require?**
Have you previously been, or are you currently, under the care of the Pain Management Service? Yes/ No	

Signed (your signature)…… Date……

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