

## WHAT IS SELF-REFERRAL

This is a new way for people to access our service. It allows you to refer yourself for physiotherapy assessment and treatment without having to see your GP first.

## WHO CAN SELF-REFER?

If you are living in the Belfast Trust area, you are over 16 years of age, you have a neck/back problem, a joint/muscle pain or a recent injury such as a sprain then you can self-refer.

## WHY SHOULD YOU SELF-REFER?

Self-referral provides you with an easier route into the physiotherapy service. It allows you to receive a timely consultation with a physiotherapist who will provide you with the support and guidance you need to help you manage your condition/injury and get you back to doing the things that matter to you.

## WHAT HAPPENS WHEN WE RECEIVE YOUR REFERRAL?

Upon receipt of your referral you will receive a confirmation email or a confirmation letter (depending on how you sent your form). Your form will then be reviewed and triaged by a senior physiotherapist.

If we need further information from you we will contact you using the details provided on your form. Your referral will then be added to the waiting list.

You will be contacted by letter or telephone to invite you to attend an appointment.

## HOW CAN YOU HELP YOURSELF WHILE YOU WAIT FOR AN APPOINTMENT?

Please see the self-management advice section on our website:  
[www.belfasttrust.hscni.net/service/musculoskeletal-physio-outpatients/](http://www.belfasttrust.hscni.net/service/musculoskeletal-physio-outpatients/)

**Please note that self-referral is not a fast track access to the Physiotherapy service, your referral will be categorised on the same basis as referrals from**

This referral option is not available if you require a home-based appointment, are under the care of a consultant for this problem, or if you have neurological / respiratory / or your continence conditions. If you have Pregnancy related pain please ask your GP/Midwife to direct you to the appropriate service.

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| First name*:<br><br>Title:                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Last name*:<br><br>                                                                                                                                                                                                                                                                                                                                                           |
| Date of Birth*:                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Health and Care (H+C) number if known:                                                                                                                                                                                                                                                                                                                                        |
| Contact details*:<br>Please provide details that you are happy to be contacted at. If we ring you it may display as 'unknown number' or 'no caller ID'<br>Phone.....<br><br>Email.....<br>.....                                                                                                                                                                                                                                                                            | Address*:<br><br><br>Post Code*:<br><br><br>Your GP name and Practice Name*:<br><br><br><br>Did your GP suggest self-referral*<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                    |
| Do you require an interpreter?<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>Do you require adjustments for reasons related to a disability*<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                  | Is this problem*<br>New <input type="checkbox"/> Return of an old problem <input type="checkbox"/><br><br>Are your symptoms getting worse?<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Are you able to carry out your normal activities, work, care for a dependant, sport etc at present*<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Where is your main problem*<br><b>Please tick one box only</b><br>Back <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/><br>Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/><br>Knee <input type="checkbox"/> Leg <input type="checkbox"/> Foot/Ankle <input type="checkbox"/><br>Multiple Joint pain <input type="checkbox"/> | How long have you had this problem*<br>0-6 weeks <input type="checkbox"/> 7-12 weeks <input type="checkbox"/><br>3mths-11mths <input type="checkbox"/> >1 year <input type="checkbox"/>                                                                                                                                                                                       |
| Have you seen your GP or anyone else in your GP practice about this problem*<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   | Do you know what caused your problem*<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                             |

Do you have any other medical conditions or information that you think may be relevant? E.g. cancer, previous fracture, diabetes, osteoporosis etc. \*

Sometimes we miss what is most important to you. What is concerning you the most?\*

Have you lost weight in the past 6 months for reasons you cannot explain?\*

Yes ☐ No ☐

Have you developed numbness/tingling/pins and needles since the start of your problem?\*

Yes ☐ No ☐

Since the onset of your problem do you have any of the following 3 symptoms?\*

A **new** episode or a **sudden** change in your ability to pass urine?

Yes ☐ No ☐

A **new** loss of sensation to your inner thighs, genitals or back passage area?

Yes ☐ No ☐

A **new** difficulty with bowel function resulting in a loss of control (soiling yourself)

Yes ☐ No ☐

If you answered **YES** to having **any** of the 3 symptoms above and you **HAVE NOT** seen a doctor for this symptom, it is **essential** that you attend your local **Emergency Department immediately**.

**DO NOT SEND THIS FORM UNTIL YOU HAVE SOUGHT FURTHER ADVICE**

I agree that the information that I have provided in this form is accurate\*

**Signature:** .....

Please ensure that all fields marked \* are completed or we will be unable to process your referral. While you are waiting if you are concerned that your condition is worsening please seek medical advice.

**On completion please return to:** Physiotherapy Central Booking Office, Mater Hospital, Crumlin Road, BT14 6AB

**Or email to:** [centralreferrals.Physio@belfasttrust.hscni.net](mailto:centralreferrals.Physio@belfasttrust.hscni.net)

# REFER YOURSELF TO PHYSIOTHERAPY

You can now refer yourself directly to  
**Musculoskeletal Physiotherapy** without having to see  
your GP

## HOW TO SELF-REFER

### \* **ONLINE FORM**

The form can be completed and submitted via our website:  
[www.belfasttrust.hscni.net/service/musculoskeletal-physio-outpatients](http://www.belfasttrust.hscni.net/service/musculoskeletal-physio-outpatients)

### \* **PAPER FORM**

The self-referral form is attached to this leaflet – please send completed forms via post or email

### \* **PDF FORM**

A printable version of the self-referral form is available to download at:  
[www.belfasttrust.hscni.net/service/musculoskeletal-physio-outpatients](http://www.belfasttrust.hscni.net/service/musculoskeletal-physio-outpatients)

Scan for  
information on  
self-managing  
your injury

