

Referral to Community Paediatric Physiotherapy Service

Please complete all areas or form will be returned.

The form should be completed electronically where possible or in block capitals

Date of Referral	
Name	
Address	
Post code	
Tel No	
Date of Birth/CHI	
Carer's name	
GP Name & Address	
School/Nursery	
Who else is involved with the child?	
Reason for referral and relevant history	
What impact are these issues having on the child and family?	
What specific change do you hope physiotherapy	

can make?	
Has the child previously had physiotherapy?	
If so, what was the outcome?	
Any other relevant information (eg medical, child protection etc) Please state if none	

Details of Person completing this form

Name	
Address	
Post code	
Tel No	
Designation/ Relationship	
Parent/Carer has agreed to referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child has agreed to this referral (if appropriate)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Signature	
Date	

Please password protect and email to
childphysio.lanarkshire@lanarkshire.scot.nhs.uk

or print and sent to the appropriate Paediatric Physiotherapy Department:-

- Hunter Health Centre, Andrew Street, East Kilbride, G74 1AD
- Douglas Street Community Health Clinic, 19 Douglas St, Hamilton, ML3 0BP
- Glendoe Building, Coathill Hospital, Hospital St., Coatbridge, ML5 4DN
- Kildrum HC, Afton Road, Cumbernauld, G67 2EU

Office use only

Date received	Signature
Letter to referrer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Letter to Parent/Carer	Yes <input type="checkbox"/> No <input type="checkbox"/>