Orthotics referral

Forms should be saved then e-mailed to: orthotics.clinic@nhs.net
Incomplete referrals will be returned to the referral source and may delay care
Referrals MUST contain NHS number, not hospital number

Patient details

Surname:

First Name:

DOB:

NHS No:

Contact No.

Address:

Postcode:

☐ Male ☐ Female

Referring Consultant / GP

Reason for referral

☐ **Footwear** ☐ **Spinal** ☐ **Upper Limb** ☐ **AFO**

☐ **Knee** ☐ **Hip** ☐ **Pressure ulcer prevention**

Objective of referral

Special precautions / medical conditions

Orthotics referral

Urgency

- ◯ Inpatient - discharge dependent
- ◯ In-patient - non urgent
- ◯ Outpatient - critical
- ◯ Outpatient - Routine

If Inpatient, Ward Number

Stabilisation Period

◯ Single issue ◯ One year ◯ Two years

Mobility

◯ Full ◯ Wheelchair ◯ Can transfer with one ◯ Hoist required

Referrer

Name:

Centre / GP Practice:

Signature: **Designation:** **Date:**

GMC/NMC No: **Contact No:**

For orthotist use only

Orthotist comment/ Orthoses ordered

Goal agreed with Patient

Name: **Sign:**

Date: **Date:**