# Orthotic Inpatient Referral Form

All sections of this form must be completed. Please **PRINT** clearly. Referrals will only be accepted if they meet the criteria for orthotic provision.

| **Orthotic department email:** | **Orthotic department telephone No:** |
|---|---|

## Referrer Details

Referrer's Name: .....

Referrer's job title: .....

Consultant: .....

Ward telephone number: .....

Ward: .....

Today's Date: .....

Planned date of discharge: .....

## Patient Details

Hospital Number: .....

NHS Number: .....

D.O.B: ..... Sex M/F

Surname: ..... Forename: .....

Address: .....

Postcode: .....

Telephone Number: .....

**Additional Information**

**Diabetic?** Yes /No **Medical / Infectious Alert?** Yes / No **if yes, please state**.....

**Child or adult Protection Issues?** Yes / No

**Communication difficulties?** Yes / No **Interpreter Required?** Yes / No Dialect: .....

**Is an orthosis required prior to discharge?** Yes / No / Uknown

**Does the patient have the capacity to consent to orthotic treatment?** Yes / No / Unsure

**Primary Diagnosis:** ..... **Patient Aware?** Yes / No

**Objectives of Orthotic Treatment: (Tick all that apply)**

Control Pain ☐ Immobilise ☐ Control Specific Joint Movement ☐ Relieve Weight ☐

Correct Deformity ☐ Protect Joint ☐ Accommodate Fixed Deformity ☐ Enhance Mobility ☐

Offload ulcer ☐ Reduce the risk of contractures ☐ Reduce the risk of falls ☐

**Relevant History: Please include pathology, presentation, and prognosis**

## To be completed by the Orthotics Department only

Triaging Orthotist (Print Name): .....

Date referral received: ..... Urgent / Routine Patient awaiting discharge? Yes / No

Additional instructions: .....

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