Orthotic Spinal Referral

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 Tel:

Surname ..... Hospital No.....

Forename ..... NHS No. .....

Address DOB .....

Postcode (or affix patient label)

Inpatient / Outpatient *(please circle)* Ward (For inpatients only) .....

Infection alert: .....

Today's Date: ..... Planned Discharge Date (For Inpatients only).....

Additional Information:

Patient's Weight: ..... Communication difficulties? .....

Child or Adult Protection Issues? Yes/No Interpreter Required? Yes/No Dialect? .....

Medical Alert? .....

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

Primary Diagnosis: ..... Patient aware? Yes /No

Which spinal levels are affected?.....

If there is a fracture present? Yes / No / Unknown

If yes, is the fracture stable? Yes / No / Unknown

Spinal neoplastic instability score (SINS score) (If applicable)? .....

Do you require any spinal levels immobilising? Yes / No

- If yes, please state which spinal levels require immobilising .....

- If no, what is the orthotic treatment aim? Pain relief ☐ Correct posture ☐

To remind the patient not to do excessive movements ☐

Other treatment aim, please state: .....

Is the plan to mobilise the patient? Yes / No - If no, is there a risk of pressure sores? Yes / No

Can the patient mobilise without a spinal brace? Yes / No

Referrer's signature: ..... Referrer's job title..... Tel: .....

Bleep: ..... Referrer's stamp:

To be completed by the Orthotics Department only

Triaging Orthotist (Print Name): ..... Date referral received: .....

Out-patient / In-patient Urgent / Routine

Appointment duration (minutes): 30 / 60 Other.....

Additional instructions: