**PRIMARY AMPUTEE REFERRAL FORM**

**REFERRER DETAILS**

|  |
| --- |
| Date of referral |
| Referring Hospital |
| Patient consented to referral Yes No |
| Referrer e-mail |

**PATIENT DETAILS**

|  |
| --- |
| Surname |
| First name |
| Date of birth |
| Home address |
| Postcode |
| Telephone |

Is an interpreter required Y N

Language required -------------------------

Visual impairment Y N

Hearing impairment Y N

Infection alert (**See Page 2**) Y N

Is patient inpatient Y N

Location / Ward --------------------------

Hospital --------------------------

Fit for assessment at rehab centre Y N

If ‘N’ expected date -------------------------

Does patient require nurse/escort Y N

**TRANSPORT REQUIREMENTS**

C1 Single crew ambulance

(patient can transfer into a car)

C2 Double man crew for patients that need carrying

C3 Single crew ambulance for patients who travel in their own wheelchair

|  |
| --- |
| Key contact name |
| Designation |
| Telephone  Bleep  Fax |

|  |
| --- |
| Gender |
| NHS Number |
| Hospital Number |
| GP Name & Address  Postcode  Telephone |

|  |
| --- |
| Planned discharge date |
| Discharge address if different to home address |

W1 Walker

B Bariatric patients

S Stretcher patients

**AMPUTATION / REVISION DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Site? level/surgical technique if known | Side (right / left) | Cause |
| Date | Site? level/surgical technique if known | Side (right / left) | Cause |
| Date | Site? level/surgical technique if known | Side (right / left) | Cause |
| Date | Site? level/surgical technique if known | Side (right /left) | Cause |

**MEDICAL HISTORY**

**Please send copies of the results of any relevant medical investigations, X-rays and swabs**

|  |  |
| --- | --- |
| Diabetic | No Type I Type II  Controlled? (no events with BM>28 over preceding 48 hours) |
| Infection Control status  Please State  Infection  Date confirmed:  Currently being treated Y N | |
| Relevant Past Medical History and/or mental Health History (**Please send copy or results of any cognition screenings)** | |
| Social History  (accommodation type / lives with / support or carers / dependents) | Has an OT access / home visit been carried out: Y N  Completed on (date) \_\_\_\_\_\_\_\_\_\_  Completed by (name & contact details) \_\_\_\_\_\_\_\_\_\_\_\_  Please E-mail the report to us :  **gst-tr.amputeeprosreferrals@nhs.net** |
| List current medications | |

**REASON FOR REFERRAL**

Rehabilitation following amputation Y / N Provision of prosthetic limb Y/N Cosmetic limb Y / N

Patient requested transfer of rehab Y / N Assessment of current prosthetic requirements Y / N

Second opinion on prosthetic option Y / N Other ……. Please state …………………………………..

Open Wound Policy Y / N

|  |
| --- |
| **WOUND / HEALING STATUS / SIZE & DESCRIPTIONS OF WOUND (Please attach photos if available)** |

|  |
| --- |
| **DRESSINGS USED**  Nurse Managing Wound (including contact details): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **COMPRESSION SOCK SIZE AND SUPPLY DATE** |

|  |
| --- |
| **STATUS OF CONTRALATERAL FOOT**  Name of DFC patient is under the care of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone Number |

PIRPAG Exercises taught Y / N

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EWA used Y / N | Date: | PPAM Aid Y / N | AMA Y / N | Femurett Y / N | Why not |

Has casting occurred Y / N or delivery of prosthesis Y / N Date / Prosthetist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | **PRE-AMPUTATION** | **CURRENT** |
| Transfers  (bed / toilet / wheelchair |  |  |
| Wheelchair |  |  |
| Gait  (distance, walking aid, limiting factors) |  |  |

**EXPECTATIONS & GOALS**

**1.**

**2.**

**3.**

Has a wheelchair referral been completed Y / N Who to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have an appropriate wheelchair Y / N

Has the patient been referred to Social Services Y / N Who to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient known to another prosthetics Centre Y / N Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Any known risk to self or others ?** |
| **Are there any safety issues when visiting?** |

**RELEVANT PROFESSIONALS / KEY CONTACTS**

|  |  |  |  |
| --- | --- | --- | --- |
| Consultant |  | Contact No / Bleep |  |
| Physiotherapist |  | Contact No / Bleep |  |
| Occupational Therapist |  | Contact No / Bleep |  |
| Counsellor |  | Contact No / Bleep |  |
| Social Worker |  | Contact No / Bleep |  |

|  |  |
| --- | --- |
| **NEXT of KIN**  (name & relation) | Contact No / Bleep |

**Referrer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please return to:**

Medical Secretary

Amputee Rehabilitation Service

Bowley Close Rehabilitation Centre

Farquhar Road

London

SE19 1SZ

Phone: 020 3049 7700

**E-mail** [**gst-tr.amputeeprosreferrals@nhs.net**](mailto:gst-tr.amputeeprosreferrals@nhs.net)

Confirmation receipt will be sent once referral is processed