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MEDICLINIC
CITY HOSPITAL

# ORTHOTIC PROSTHETIC SERVICES REFERRAL FORM

## REFERRER DETAILS

Date _____ Referral location _____
Referrer _____ Speciality _____
Contact number _____ Contact referrer ☐ Yes ☐No

## PATIENT DETAILS

Surname _____ First name _____
Gender (optional) ☐Female ☐Male DOB _____
Adress (optional) _____ Mobile _____
☐ Outpatient ☐ Inpatient Ward _____
First language (optional) _____ Interpreter required ☐ Yes ☐No

## DIAGNOSIS INCLUDING PRIMARY CONDITION

*Relative history/summary of functional loss if required*

## PROPOSED GOALS OF TREATMENT

*Including plans for other treatment interventions if any (e.g. botox, surgery)*

## PROSTHETIC SERVICES

- ☐ Evaluate and recommend treatment
- ☐ Pre-amputation consultation
- ☐ Immediate post operative care
  - ☐ Removable limb protector
  - ☐ Rigid dressing
  - ☐ Shrinker
- ☐ Prosthetic fitting
- ☐ High definition silicone cosmetic

- ☐ Mastectomy product / prosthesis
- ☐ Compression hosiery

Class: ☐1 ☐2 ☐3 ☐4

## ORTHOTIC SERVICES

- ☐ Evaluate and recommend treatment
- ☐ Custom foot orthotic program
- ☐ Lower extremity bracing
- ☐ Upper extremity bracing
- ☐ Spinal bracing
  - ☐ Custom ☐ Scoliosis
  - ☐ Off-the shelf ☐ Boston
- ☐ Cranial remoulding orthosis
- ☐ Specialized footwear
  - ☐ Orthopaedic ☐ Diabetic
  - ☐ Comfort ☐ Custom

## SPECIAL INSTRUCTIONS *(please specify requirements if any)*

## SPECIAL NEEDS/RISKS *(past/recent surgery if related)*

Signature _____ Date _____
*Referrer*

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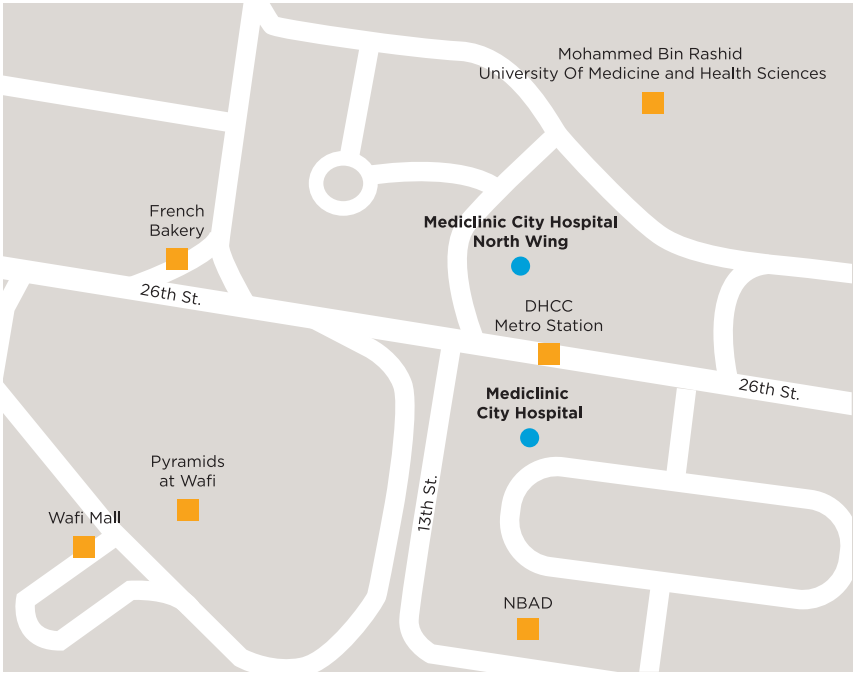


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