North Bristol NHS
NHS Trust

SPINAL ORTHOTIC REFERRAL FORM DSC113

PLEASE COMPLETE ALL SECTIONS OF THIS FORM (USING BLOCK CAPITALS) – ALL INCOMPLETE REFERRALS WILL BE RETURNED

Please return completed form to the following address:

Bristol Centre for Enablement
Highwood Pavilions
Jupiter Road
BS34 5BW

You can e-mail your referral to orthotics@nbt.nhs.uk

Patient Details:

Surname:	**NHS no:**
Forenames:	**Sex: M/F** **Diabetic: Y/N**
Mr/Mrs/Miss/Other:	**Date of Birth:**
Address: **Postcode:**	**GP Name:**
Telephone No:	**GP Address:** **Postcode:**
e-mail:	**GP Telephone No:**

Please state ALL spinal levels affected: ______________________________
Mechanism of Injury: ______________________________
If a fracture is present, is it stable: **Yes** ☐ **No** ☐

Are any other injuries present?

Aim of Treatment:
- ☐ Immobilise spinal level stated above
- ☐ Pain relief
- ☐ Remind patient to avoid excessive movements
- ☐ Other, please state:______________________________

Is the brace required PRIOR to mobilisation? **Yes** ☐ **No** ☐

P.T.O

Significant History & Active Problems:

Relevant Medication/Allergies/Infection Risk:

Referrer Details:

Name:

Position:

Location

Tel No:

Inpatient: Yes / No

Date:

Ward:

Signature:

E-mail:

What Speciality are you referring on behalf of? **(Circle as appropriate)**

GP	**Medicine**	**Children's Services**	**Neurosciences**
Renal	**Rheumatology**	**Women's Health**	
Surgery	**Orthopaedics**	**Other, Please Specify……………………………….**	

For Orthotic Use Only:

Priority: ***URGENT / ROUTINE***

Referral Type: *(circle as appropriate)*

Insoles	*Footwear*	*Lower Limb Brace*	*Upper Limb Brace*
Body Brace	*Hosiery*	*Wig*	*OTHER*