BRISTOL CENTRE FOR ENABLEMENT
LIMB PROSTHETICS REFERRAL FORM

Highwood Pavilions
Jupiter Road
Patchway
Bristol BS34 5BW 0117 414 4900 Fax: 0117 340 4654

Please complete all sections of this form. Incomplete forms may be returned before processing.

REFERRER DETAILS

Hospital	**Ward**
Consultant	**Tel. No.**

PATIENT DETAILS

Note: NHS No. is mandatory.

Surname **Mr / Mrs / Miss**
Forenames
Home Address

Post Code
Tel. No. **Date of Birth**
NHS No. ______________________________
Patient will be/was discharged on:
Please indicate discharge address overleaf if different from above
Transport required? Yes / No

GP DETAILS

Name
Address

Post Code **Tel:**

PRIMARY CAUSE OF AMPUTATION
SITE OF AMPUTATION **Left (Level)** **Right (Level)** **Date**

CLINICAL HISTORY LEADING TO AMPUTATION

CONCURRENT DISABILITIES / MEDICAL CONDITIONS (Continue overleaf if necessary)

MEDICATION

INFECTION RISK
Eg: Hep B, MRSA
Please provide further details overleaf

ALLERGIES

SIGNATURE OF REFERRER **DATE**
NAME **Consultant / Sen Registrar / Registrar**

Form Approval Signature:

ADDITIONAL INFORMATION

DISCHARGE ADDRESS
If different from address given overleaf:

Form Approval Signature: