ORTHOTIC REFERRAL FORM DSC113

North Bristol NHS
NHS Trust

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
Tel No: 0117 414 4900

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

Patient Details:

NHS no:

Surname:

Sex: M/F

Diabetic: Y/N

Forenames:

Date of Birth:

Mr/Mrs/Miss/Other:

GP Name:

Address:

Postcode:

GP Address:

Postcode:

Telephone No:

GP Telephone No:

Clinical Diagnosis:

Orthotic Treatment Objective:

For Hosiery, please indicate class: 1 2 3 4

Approval Signature:

P.T.O

Significant History & Active Problems:

Relevant Medication/Allergies/Infection Risk:

Referrer Details:

Name:

Position:

Location

Tel No:

Inpatient: Yes / No

Date:

E-mail:

Ward:

Signature:

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*

Approval Signature: