

# ORTHOTIC REFERRAL FORM

Weston Area Health 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](mailto:orthotics@nbt.nhs.uk)

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

<b>Clinical Diagnosis:</b>
<b>Orthotic Treatment Objective:</b>
<b>For Hosiery, please indicate class: 1 2 3 4</b>



Significant History & Active Problems:
Relevant Medication/Allergies/Infection Risk:

<b>Referrer Details:</b>			
<b>Name:</b>	<b>Position:</b>		
<b>Location</b>	<b>Tel No:</b>		
Inpatient: Yes / No	<b>Date:</b>		
Ward:	<b>Signature:</b>		
<b>E-mail:</b>			
<b>What Speciality are you referring on behalf of? (Circle as appropriate)</b>			
GP Renal Surgery	Medicine Rheumatology Orthopaedics	Children's Services Women's Health Other, Please Specify.....	Neurosciences

<b>FOR ORTHOTIC USE ONLY:</b>			
<b>Priority:</b>	<i>URGENT / ROUTINE</i>		
<b>Referral Type: (circle as appropriate)</b>			
<i>Insoles</i>	<i>Footwear</i>	<i>Lower Limb Brace</i>	<i>Upper Limb Brace</i>
<i>Body Brace</i>	<i>Hosiery</i>	<i>Wig</i>	<i>OTHER</i>

