

**Orthotic Referral Form – Knee Brace**

Please return your completed form to orthotics@nbt.nhs.uk

If you have any queries prior to referring, please contact the service on (0117) 4144900

|  |  |
| --- | --- |
| **Client Details** | **GP Details** |
| NHS Number |  | GP Name |  |
| Title |  | Nat GP Code |  |
| Forename |  | Telephone No |  |
| Surname |  | Surgery Name |  |
| DOB  |  (DD/MM/YYYY) | Surgery Address |  |
| Gender |  |
| Diabetic | Yes |  | No |  | Surgery Postcode |  |
| House Name |  |
| Address 1 |  |
| Address 2 |  |
| Town |  |
| County |  |
| Postcode |  |
| Email Address |  |
| Telephone No |  | Mobile No |  |
| Ethnicity |  |
| **Medical Conditions** |
| Clinical Diagnosis (Circle/delete as appropriate) | Medial OALateral OARight/LeftSurgical Plan:  |
| Height | Circumference at 15cms above……..Circumference at 15cms below……..Circumference at Knee……………… |
| Objective of Knee Brace |   |
| Significant History & Active Problems |  |
| **Referrer Details** |
| Name |  |
| Location / Ward |  |
| Designation |  |
| Lead Consultant  |  |
| Email Address |  | Telephone |  |
| Inpatient | Yes |  | No |  |
| What Speciality are you referring on behalf of? |
| GP |  | Medicine |  | Children’s Services |  |
| Renal |  | Rheumatology |  | Women’s Heath |  |
| Neurosciences |  | Surgery |  | Orthopaedics |  |
| Other, Please Specify |  |  |
| Date |  **(DD/MM/YYYY)** |
| Signature |  |