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 OA Lateral OA Right/Left Surgical 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							