

Orthotic Referral Form – Spinal Brace

Please return your completed form to [orthotics@nbt.nhs.uk](mailto: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** | | | | | | | | | | | | | | | | |
| Please state ALL spinal levels affected | | | | |  | | | | | | | | | | | |
| Mechanism of Injury | | | | |  | | | | | | | | | | | |
| If a fracture is present, if so is it stable? (please delete as appropriate) | | | | | Yes / No | | | | | | | | | | | |
| Are any other injuries present? (please delete as appropriate) | | | | | Yes / No | | | | | | | | | | | |
| Aim of Treatment (Please delete as appropriate) | | | | | Immobilise spinal level stated above  Pain relief  Remind patient to avoid excessive movements  Other, please state: | | | | | | | | | | | |
| Is the Brace required prior to mobilization (Please delete as appropriate) | | | | | Yes / No | | | | | | | | | | | |
| Significant History & Active Problems | | | | |  | | | | | | | | | | | |
| Relevant Medication / Allergies / Infection Risk: | | | | |  | | | | | | | | | | | |
| **Referrers 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 | | | |  | | | | | | | | | | | | |