

Orthotic Referral Form – Spinal 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

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| --- | --- |
| **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 abovePain reliefRemind patient to avoid excessive movementsOther, 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 |  |