NHS
North Bristol
NHS Trust

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

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					