Referral Form to Rehabilitation Services

(incl. Prosthetics) for Patients with Limb Loss/Deficiency

NHS
Birmingham Community Healthcare
NHS Foundation Trust

Referral may be made by any relevant Health Care Professional, including: Consultant, Registrar, Senior Physiotherapist/ Occupational Therapist, Named Nurse, General Practitioner, Practice Nurse, Health Visitor. When the referral has been completed fully, post to:

The Medical Records Department, West Midlands Rehabilitation Centre, 91 Oak Tree Lane, Selly Oak, B29 6JA or if urgent, fax to 0121 471 3690 or email: bchnt.soar@nhs.net

Please ensure this form is completed in full—it provides essential information. Failure to do so will result in unnecessary delay in processing this referral.

Please email your completed form to: **bchnt.soar@nhs.net**

COVID STATUS

COVID Positive: ☐ Yes ☐ No ☐ Unknown **Date of result:** **Date of onset:**

Symptoms:

Patient Details	
Surname:	Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss
Forename(s):	D.o.B:
Address:	NHS Number (Not Hosp. No.):
	Marital Status:
Post Code:	Sex:
Interpreter required: ☐ Yes ☐ No	Telephone No:
Name of Next of Kin:	Contact details of Next of Kin:

***Ethnic Origin:** Please select the most appropriate group

(A) White British
(B) White Irish
(C) White Other
(D) Mixed White and Black Caribbean
(E) Mixed White and Black African
(F) Mixed White and Asian
(G) Mixed any Other
(H) Indian or British Indian
(J) Pakistani or British Pakistani
(K) Bangladeshi or British Bangladeshi
(L) Asian British/Any Other Asian Background
(M) Black or Black British Caribbean
(N) Black or Black British African
(P) Black or Black British any other Black Background
(R) Chinese
(S) Any other Ethic Group

Doctor's Details	
Registered General Practitioner:	Hospital Consultant:
Address:	Hospital Ward/ Address:
Post Code:	Post Code:
Telephone No:	Telephone No:

Service provided by
Blatchford

Transport Needs

If patient in hospital, planned discharge date:

Following discharge, will patient need transport? ☐ Yes ☐ No ☐ Stretcher ☐ 2ML ☐ Sit ☐ Car

Will an escort be required for medical reasons? ☐ Yes ☐ No

If yes, please give details:

Clinical Details (delete as applicable)

1. Is there a Congenital Limb Deficiency? ☐ Yes ☐ No

2. Has an Amputation already been carried out? ☐ Yes ☐ No

3. If Yes: Side/Level of Amputation

Date of Amputation

Reason for Amputation

4. If No: Is a Pre-amputation Consultation requested? ☐ Yes ☐ No

5. If Yes: Side/Level of proposed Amputation

Date of proposed Amputation

Reason for proposed Amputation

6. Is patient Diabetic? ☐ Yes ☐ No
(N.B. Ensure status tested within last 3 months)

7. Other medical conditions/disabilities: Medication:

Allergies:

8. When Lower Limb involved: Condition of contra-lateral leg?

9. Functional Abilities (Transfers, PADLs etc.):

10. Other Information (Housing, Social information etc.):

(Please forward any Multi-disciplinary/Home Visit Reports etc. when completed.)

Weight (kg)	**Height:**

Form competed by (please print):

Signature: Date:

Job Title: Contact No:

Thank you for completing this form. It will be processed within 5 days. Depending on the information you have provided, the patient may be visited by a Consultant in Rehabilitation Medicine on the ward, or an outpatient appointment will be made for them to attend our Centre for a multi-disciplinary assessment. This will normally be within 1 month.

N.B. Please ensure ALL Medical Notes, X-Rays, and Multi-Disciplinary Reports accompany patient (if still in hospital) when attending our Centre.

OFFICIAL USE ONLY

Date Recieved: Consultant: Clinical Code:

DATA PROTECTION ACT 1998

Personal data supplied on this form may be held on and or verified by reference to information already held on computer. The Caldicott Report concludes that all items of information that relates to an individual should be treated as potentially capable of identifying a patient to a greater or lesser extent and appropriately protected to safeguard confidentiality.