

REFERRAL FOR ASSESSMENT/CONSIDERATION OF LIMB PROSTHESIS

Phone: 0116 296 8400

Email: prosthetics.leicester1@nhs.net

Address: Leicester Specialist Mobility Centre (Opcare), 17a Meridian East, Leicester, LE19 1WZ

REFERRED BY:
HOSPITAL:
WARD:
TEL:
CONSULTANT:

NHS NUMBER:

DATE OF BIRTH:

Patient name:
Patient Address:
Patient tel :
GP name and address:
Tel:

Clinical Notes

PRIMARY CAUSE OF AMPUTATION:

DATE OF AMPUTATION:

SIDE(S) OF AMPUTATION:
LEVEL OF AMP:

PRE-AMPUTATION HISTORY:

PLEASE COMPLETE FURTHER CLINICAL NOTES OVERLEAF

POST AMPUTATION COURSE:

ADDITIONAL DISABILITIES & CURRENT MEDICATION:

IS HOSPITAL TRANSPORT REQUIRED FOR THE APPOINTMENT? If so, is it a car or ambulance?

THIS PATIENT WILL BE DISCHARGED ON:

DISCHARGED TO? E.g. Home

Patient aware of referral?

SIGNED:

DATE:

NAME:

PROFESSION:

Phone Number/Bleep: