REFERRAL TO PROSTHETICS SERVICE: WESTMARC CENTRE

This form must be completed by the appropriate therapist, nurse or doctor currently working with the patient. **Superscript numbers in brackets (e.g. (3)) refer to Guidance Notes (PSG02).**

All details must be completed to avoid unnecessary delay.

PATIENT DETAILS

Surname________________________________

First Name: ____________________________

Sex: M ☐ F ☐ DoB: ______________

Permanent Address(2) : ______________

____

Postcode: ______________________________

☎:______________________

Emergency contact / next of kin:

Name: _________________________________

☎: ____________________________

REFERRAL TYPE please tick (✓)

Pre-amputation ☐ Transfer ☐

Primary ☐ Review - *patient now bilateral* ☐

Review - *revision* ☐

In-Patient ☐ **Out-Patient** ☒

if In-Patient:

Hospital: ______________________________

Ward: ___________________ ☎: _____________

Unit No: ___________Consultant: ______________

AMPUTATING HOSPITAL (can be same as above)

____

GENERAL PRACTITIONER

Name: _________________________________

Address:______________________________________

☎: __________ GP Code:________________

CHI No: ________________________

SPARG No(3) : ______________________________

CONDITION DETAILS

Site of Amputation: Side: Left ☒ Right ☐ Level ☐ (4) : …………………… **Date of Amputation:** ………………………..

Primary Cause of Amputation (5) **TICK ONE BOX ONLY:**

- ■ DYSVASCULARITY: PAD(6) without Diabetes ☐ / PAD with Diabetes(7) ☐ / Acute Vascular Incident(8) ☐ / Other ☐
- ■ TRAUMA: Mechanicalx ☐ / Thermal ☐ / Electrical ☐ / Chemical ☐ / Radioactive ☐
- ■ DEFORMITY: Present at birth ☐ / Acquired ☐
- ■ INFECTION: Soft tissue ☐ / Bone ☐ / Joints ☐
- ■ NEUROLOGICAL DISORDER: Congenital Abnormality ☐ / Injury ☐ / Infection ☐ / Systemic Disease ☐ / Other ☐
- ■ NEOPLASM: Benign Tumour ☐ / Malignant Primary Tumour ☐ / Malignant Secondary Tumour ☐

MEDICAL ALERT?(9) Yes ☐ No ☐

Check patient's Medical Record for details of any medical alert

IS THE PATIENT DIABETIC? IDDM (10) ☐ Non-IDDM ☐

Please complete this section in addition to the Primary Cause of Amputation

EXPECTED DATE OF FIRST VISIT TO PROSTHETICS SERVICE CENTRE(11):

Proposed date of discharge: ……………………………To permanent address as entered above? Yes ☐ No ☐

If 'No', insert new address: ……………………………………………………………………………………………………

PROSTHETICS SERVICE OFFICE USE ONLY

Prosthetics Service Unit No: ………………………………… Health Board of Residence: ……………………………

Name:	**DoB:**

RELEVANT MEDICAL HISTORY (Including pre- and post-operative history. Continue on a separate sheet if necessary):

RELEVANT PATIENT INFORMATION: N.B. Patient weight information is mandatory. Items in *italics* are optional

Patient's Weight[12]: … **Static** ☐ **Increasing** ☐ **Decreasing** ☐

Dominant Side (only required for upper limb amputee): Left ☐ *Right* ☐

Occupation: ……………………………………………….. *Hobbies:* …………………………………………………………

Accommodation[13]: ………………………………………………………………………………………………………..

WHEELCHAIR

Has wheelchair assessment/prescription been completed? Yes ☐ No x☐

Ability to Transfer: Unable ☐ With assistance ☐ With walking aids ☐ Independent ☐x

REHABILITATION PROGRESS: Please complete a **Therapy Update Sheet** and send it **with** this form if a Prosthetics Service appointment is likely to be required/arranged within 7 days. If the appointment is more than 7 days away, please send an Update Sheet with the patient or fax a copy to the centre (Fax No. 0131 536 4840) to arrive prior to the appointment.

OTHER RELEVANT INFORMATION/TREATMENT

TRANSPORT REQUIREMENTS[14]

Own transport ☐ Ambulance: 2-man ☐ 1-man ☐ Ambulance Car ☐

Other relevant details:

……………………………………………………………………………………………………..

COMMUNICATION

Does the patient have communication difficulties? No ☐ Yes ☐ If yes, patient should be accompanied at **each** visit Slightly deaf but no significant disability.

Does the patient require translation services? No x☐ Yes ☐ If yes, state language

KEY CONTACTS

Inpatient Physiotherapist: Name: ……………………………………………………….. ☎: …………………………..

Outpatient Physiotherapist: Name: ……………………………… Centre: ……………… _ ☎: ……………………………

Occupational Therapist: Name: ……………………………… Centre: ……………… _ ☎:……………………………

Prosthetist[15]**:** Name: ……………………………… Centre: ……………… ☎: ……………………………

REFERRAL SOURCE Print Name: ……………………………….. Job Title: ………………………………………………

Signature: …………………………………….. Date: _: ………………….. ☎: ………………………………………………

PLEASE SEND THE COMPLETED FORM TO:

Prosthetics Service, Westmarc, Queen Elizabeth University Hospital, 1345 Govan Road, Glasgow, G51 4TF
Telephone: 0141 201 1215
Fax: 0141 201 2649

An electronic (PDF) version of this form is available – please contact the Prosthetics Service Manager at the above address
This form was developed by the Prosthetics Service Group of the Scottish Rehabilitation Technology Services Provider Forum (ScotRet)