Orthotics Referral Form

**All sections of this form must be completed**

**REFERRER’S DETAILS**

|  |  |
| --- | --- |
| Name |  |
| NHS Trust and team name |  |
| GP Surgery |  |
| Position/Profession |  |
| Contact No *(preferably bleep)* |  |
| Date of referral |  |
| Where patient was seen (e.g. home, ward, out-patients clinic) |  |

**REFERRING TO – please tick**

|  |  |
| --- | --- |
| Royal Bournemouth Hospital – Prosthetics and Orthotics Centre (Patients in Bournemouth) | 🞏 |
| Dorset HealthCare – Orthotics Service | 🞏 |
| Dorset County Hospital (Patients DT1-DT4) | 🞏 |

**PATIENT DETAILS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | | |  | | | |
| NHS Number | | |  | | | |
| DOB | | |  | | | |
| Address/Ward | | |  | | | |
| Telephone/Mobile Number | | |  | | | |
| **Primary Diagnosis** – Patient aware Yes/No  **Diabetic Yes /No** | | | | | | |
| **Significant medical history** | | | | | | |
| **Specific anatomical considerations** | | | | | | |
| **Orthotic device already trialled:**  Device  Outcome | | | | | | |
| **Objectives of Treatment** | | | | | | |
| Pain Management | 🞏 | Immobilise | | 🞏 | Control specific joint movement | 🞏 |
| Correct Deformity | 🞏 | Protect Joint | | 🞏 | Accommodate fixed deformity | 🞏 |
| Weight Management | 🞏 | Enhance Mobility | | 🞏 | Offload ulcer | 🞏 |

# **Guidelines for requesting the Orthotics service**

An orthosis is a brace or splint which provides correction, support and/or protection to a part of the body based on the principles of biomechanics. An orthosis is usually provided by an Orthotist following an assessment.

Please consider before referring: - The patient has trialled shop bought insoles/gel insoles or blue spots as appropriate?

Does the patient have a long-term condition or co-morbidities in addition to the presenting problem?

Please see referral guidelines to ensure that the patient is eligible for Orthotic intervention.

All referrals are a request for an assessment and **NOT a prescription**. Referrals will only be accepted if they meet the criteria for orthotic provision and the referral form is completed in full.

**Please email this referral form for triaging to**

|  |  |
| --- | --- |
| **Royal Bournemouth Hospital –**  **Prosthetics and Orthotics Centre**  **(Patients in Bournemouth, Christchurch, Ferndown, West Moors)** | [**Orthotics.Referrals@rbch.nhs.uk**](mailto:Orthotics.Referrals@rbch.nhs.uk)  **Telephone 0300 019 43 63** |
| **Dorset HealthCare – Orthotics Service**  PLEASE NOTE | [**dhc.orthotics.service@nhs.net**](mailto:dhc.orthotics.service@nhs.net)  **Telephone 0300 019 22 98**  **If you have access to SystmOne**  **Send Electronic Referral and save this form in the patient record.** |
| **Dorset County Hospital (Patients DT1-DT4)** | [**Orthotics@dchft.nhs.uk**](mailto:Orthotics@dchft.nhs.uk)  **Telephone 01305 25 44 08** |
| **Salisbury Orthotics**  **(Patients SP7 & SP8)**  **clinics run in Shaftsbury** | [**sft.orthotics@nhs.net**](mailto:sft.orthotics@nhs.net)  **Telephone 01722 429175** |