THERAPY SERVICES

Referral to Orthotic Services

Airedale NHS
NHS Foundation Trust

Please complete both sides of this form - Fax both pages on the day of referral
FAX 01535 295436

PATIENT DETAILS			
Surname		D.O.B	
Forename		NHS No.	
Title	Mr / Mrs / Miss / Dr / Other	AGH No.	
Address		Consultant	
		GP and Surgery	
Postcode			

Telephone Numbers (please circle preferred telephone number)			
Day Number : Evening Number: Mobile Number:			
Carer's Name (If relevant)		Carer's relationship to patient	
Carer's Telephone Number			

Other

Ethnicity:
Language (If not English): Interpreter required: Yes☐ No☐
Can the patient attend clinic: Yes☐ No☐ Transport needs: Yes☐ No☐
SC☐ T1☐ T2☐ W1☐ W2☐ STR☐ ESC☐

Patient status

Outpatient☐ Inpatient☐ Private patient Yes☐ No☐
Ward:

PRIORITY

Urgent☐ Soon☐ Routine☐

Are there any known risks to staff? Yes☐ No☐

If Yes, please give details:

Are there any safeguarding issues? Yes☐ No☐

If yes please give details:

DIAGNOSIS, PAST MEDICAL HISTORY, MEDICATION, OTHER PLANNED INTERVENTIONS

PATIENT DETAILS			
Surname		D.O.B	

AREA OF BODY AFFECTED

OBJECTIVES OF ORTHOTIC TREATMENT			
Hold a joint		Relieve weight	
Protect joints		Control specific joint movements	
Prevent undesired movement within a joint		Promote movement of a joint	
Accommodate joint deformity		Reduce symptoms of circulatory problems	
Other (specify):			

OTHER SERVICES/AGENCIES INVOLVED AND SOCIAL SITUATION (designations and contact numbers)

CONSENT
Patient is aware of and has agreed to this referral Yes☐ No☐ If no, please explain

REFERRER	
Date of referral:	Referrer designation:
Referrer name (please print):	Referrer signature:
Referrer's address:	Referrer's telephone no:

THERAPY USE ONLY	
Date Referral Received:	
Category:	Grade:
Comments:	
Signature:	Date:

Please fax this form to 01535 295436 or post to Mobility Services Department, Steeton, Keighley, West Yorkshire BD20 6TD Tel 01535 292607