THERAPY SERVICES - Referral to Orthotic Services

Please complete all sections and send via secure email to agh.orthotics@nhs.net or fax to 01535 295436

Airedale NHS Foundation Trust

Patients must meet ALL of the following criteria to be assessed for orthotic services (TICK ALL)

☐ Registered with a GP in the Airedale, Wharfedale & Craven clinical commissioning area incl Bentham
☐ Lawfully entitled to reside in the UK and to receive NHS treatment for use in their own home
☐ Has an acute or long term condition requiring specialist orthotic assessment

The orthotic service is for specialist assessment and prescription of orthoses to manage acute and long term conditions to improve posture, function and mobility and reduce pain.

Airedale Orthotic services **DO NOT prescribe for**

- Simple devices available from retailers
- Footwear for deformity where the measurement range is within retailer parameters
- Recurrent patella dislocation or Osgood Schlatters disease
- Insoles for plantar pain unless off the shelf devices and exercises have been tried
- Safety footwear which an employer should provide
- Items solely for sporting or educational need

CLIENT DETAILS	**REFERRAL DATE** _____
Surname	DOB
Forename Title Mr / Mrs / Miss / Dr / Other	NHS No.
Address Postcode	Telephone Numbers Day Number : Evening Number: Mobile Number:
Carer's name, address and telephone number:	Is this request ☐ urgent or ☐ routine
Is the client an In-patient? ☐ Yes Ward number ___ ☐ No	

Referrer's Name & professional designation	**GP's Name and Address**
Designation: Tel No Fax No Signature	Tel No Fax No Signature

Ethnicity:
Language (If not English): Interpreter required: ☐ Yes ☐ No

Can the client attend clinic: ☐ Yes ☐ No Please tell us why if not _____

Does the client require transport ☐ Yes ☐ No Type of transport required (see overleaf)

SC☐ T1☐ T2☐ W1☐ W2☐ STR☐ ESC☐

Please tell us any known risks to staff

Please tell us if there are any safeguarding concerns

DIAGNOSIS, CURRENT MEDICATION & PAST MEDICAL HISTORY relevant to this referral ONLY include any planned interventions

AREA OF BODY AFFECTED

OBJECTIVES OF ORTHOTIC TREATMENT (tick all which apply)

☐ Hold/Protect a joint ☐ Prevent movement in a joint ☐ Relieve weight or pressure
☐ Reduce circulatory problems ☐ Facilitate discharge ☐ Pain relief
☐ Contracture prevention ☐ Improve posture/mobility ☐ Prevent deterioration
☐ Reduce risk of falls

SELF-CARE Please indicate which options have already been explored (tick as many as applicable)

☐ Exercises/Physiotherapy ☐ Off the shelf insoles ☐ Off the shelf bracing/support
☐ Wide/deep fitting footwear ☐ Standard hosiery ☐ Not known

☐ Other please state

CONSENT

Patient is aware of and has agreed to this referral ☐ YES ☐ NO please explain

Type of transport
SC Driver only saloon car T1 Ambulance, can transfer T2 Attendant W1 Ambulance can't transfer W2 Attendant can't transfer STR Stretcher ESC = escort required 3ML/4ML Bariatric