

Orthotic Referral Form

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Patient details:

Name:

Date of birth:

NHS number:

Date of referral:

Outpatient/inpatient:

Inpatient ward :

Orthosis required for discharge?

Date NOC follow-up:

Has anticoagulant been considered or provided? *(Required for immobilising walker)*:

Diagnosis:

*Primary*:

*Other*:

Presenting problem:

Orthosis objective *e.g. short term/long term*:

Other relevant medical information *e.g. diabetes, neuropathy, pain, life limiting condition*:

Is the patient receiving or awaiting other treatment *e.g. surgery, physio, wheelchair, podiatry?*

Is there a clinical reason for this patient to be seen urgently? *(Please specify)*:

Referrer (print name):

Signature:

Referrer contact details:

*Please complete all information; incomplete or unclear forms will be returned to the referrer for more information.*