

## Orthotic Referral Form

Department of Orthotics, Windmill Road, Headington, Oxford, Tel: 01865 227570, e-mail: ouh.orthotics@nhs.net

<b>Patient Details</b> <i>(please attach label)</i>  Hosp No/Address	<b>Date of referral</b>	
	<b>Outpatient / Inpatient</b>	
	<b>Inpatient Ward</b>	
	<b>Is Orthosis required for discharge?</b>	
	<b>Date NOC FU</b>	
<b>Diagnosis:</b> <i>Primary</i>		<i>Other</i>
<b>Musculoskeletal/Functional Problems</b>		
<b>Orthosis objective</b> <i>e.g. prevent plantarflexion, correct deformity</i>		
<b>Orthosis Recommended</b>		
<b>Other relevant Medical information</b> <i>e.g. Diabetes, Neuropathy, Pain, life limiting condition</i>		
<b>Is the patient receiving or awaiting other treatment?</b> <i>(please give details)</i> <i>e.g. Surgery, Physio, Wheelchair, Podiatry</i>		
<b>Is there a clinical reason for this patient to be seen urgently?</b> <i>(please specify)</i>		
<b>Referrer</b> <i>(Print Name)</i>  <b>Signature</b>	<b>Referrer contact details</b>	

Please complete all relevant information, incomplete or illegible forms will be returned to the referrer for more information.

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