

## REFERRAL TO PROSTHETICS SERVICE: WESTMARC CENTRE








This form must be completed by the appropriate therapist, nurse or doctor currently working with the patient. **Superscript numbers in brackets (e.g. <sup>(3)</sup>)** refer to **Guidance Notes (PSG02)**.

All details must be completed to avoid unnecessary delay.

<p><b><u>PATIENT DETAILS</u></b></p> <p>Surname _____</p> <p>First Name: _____</p> <p>Sex: M <input type="checkbox"/> F <input type="checkbox"/> DoB: _____</p> <p>Permanent Address<sup>(2)</sup>: _____</p> <p>_____</p> <p>Postcode: _____</p> <p>☎: _____</p> <p><b><u>Emergency contact / next of kin:</u></b></p> <p>Name: _____</p> <p>☎: _____</p>	<p><b><u>REFERRAL TYPE</u></b> please tick (✓)</p> <p>Pre-amputation <input type="checkbox"/> Transfer <input type="checkbox"/></p> <p>Primary <input type="checkbox"/> Review - <i>patient now bilateral</i> <input type="checkbox"/></p> <p>Review - <i>revision</i> <input type="checkbox"/></p> <hr/> <p><b><u>In-Patient</u></b> <input type="checkbox"/> <b><u>Out-Patient</u></b> <input checked="" type="checkbox"/></p> <p style="text-align: center;"><b>if In-Patient:</b></p> <p>Hospital: _____</p> <p>Ward: _____ ☎: _____</p> <p>Unit No: _____ Consultant: _____</p> <p><b><u>AMPUTATING HOSPITAL</u></b> (can be same as above)</p> <p>_____</p>						
<p><b><u>GENERAL PRACTITIONER</u></b></p> <p>Name: _____</p> <p>Address: _____</p> <p>☎: _____ GP Code: _____</p>	<p><b><u>CHI No:</u></b> _____</p> <p><b><u>SPARG No<sup>(3)</sup>:</u></b> _____</p>						
<p><b><u>CONDITION DETAILS</u></b></p> <p><b><u>Site of Amputation:</u></b> Side: Left <input checked="" type="checkbox"/> Right <input type="checkbox"/> Level <input type="checkbox"/> <sup>(4)</sup> : ..... <b><u>Date of Amputation:</u></b> .....</p> <p><b><u>Primary Cause of Amputation</u></b> <sup>(5)</sup> <b>TICK ONE BOX ONLY:</b></p> <table border="0"> <tr> <td data-bbox="63 1339 718 1444"> <p>■ <b>DYSVASCULARITY:</b></p> <p>PAD<sup>(6)</sup> without Diabetes <input type="checkbox"/></p> <p>PAD with Diabetes<sup>(7)</sup> <input type="checkbox"/></p> <p>Acute Vascular Incident<sup>(8)</sup> <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p> </td> <td data-bbox="750 1339 1516 1422"> <p>■ <b>INFECTION:</b></p> <p>Soft tissue <input type="checkbox"/></p> <p>Bone <input type="checkbox"/></p> <p>Joints <input type="checkbox"/></p> </td> </tr> <tr> <td data-bbox="63 1467 718 1612"> <p>■ <b>TRAUMA:</b></p> <p>Mechanical <input checked="" type="checkbox"/></p> <p>Thermal <input type="checkbox"/></p> <p>Electrical <input type="checkbox"/></p> <p>Chemical <input type="checkbox"/></p> <p>Radioactive <input type="checkbox"/></p> </td> <td data-bbox="750 1444 1516 1590"> <p>■ <b>NEUROLOGICAL DISORDER:</b></p> <p>Congenital Abnormality <input type="checkbox"/></p> <p>Injury <input type="checkbox"/></p> <p>Infection <input type="checkbox"/></p> <p>Systemic Disease <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p> </td> </tr> <tr> <td data-bbox="63 1635 718 1702"> <p>■ <b>DEFORMITY</b></p> <p>Present at birth <input type="checkbox"/></p> <p>Acquired <input type="checkbox"/></p> </td> <td data-bbox="750 1612 1516 1702"> <p>■ <b>NEOPLASM:</b></p> <p>Benign Tumour <input type="checkbox"/></p> <p>Malignant Primary Tumour <input type="checkbox"/></p> <p>Malignant Secondary Tumour <input type="checkbox"/></p> </td> </tr> </table>		<p>■ <b>DYSVASCULARITY:</b></p> <p>PAD<sup>(6)</sup> without Diabetes <input type="checkbox"/></p> <p>PAD with Diabetes<sup>(7)</sup> <input type="checkbox"/></p> <p>Acute Vascular Incident<sup>(8)</sup> <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p>■ <b>INFECTION:</b></p> <p>Soft tissue <input type="checkbox"/></p> <p>Bone <input type="checkbox"/></p> <p>Joints <input type="checkbox"/></p>	<p>■ <b>TRAUMA:</b></p> <p>Mechanical <input checked="" type="checkbox"/></p> <p>Thermal <input type="checkbox"/></p> <p>Electrical <input type="checkbox"/></p> <p>Chemical <input type="checkbox"/></p> <p>Radioactive <input type="checkbox"/></p>	<p>■ <b>NEUROLOGICAL DISORDER:</b></p> <p>Congenital Abnormality <input type="checkbox"/></p> <p>Injury <input type="checkbox"/></p> <p>Infection <input type="checkbox"/></p> <p>Systemic Disease <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p>■ <b>DEFORMITY</b></p> <p>Present at birth <input type="checkbox"/></p> <p>Acquired <input type="checkbox"/></p>	<p>■ <b>NEOPLASM:</b></p> <p>Benign Tumour <input type="checkbox"/></p> <p>Malignant Primary Tumour <input type="checkbox"/></p> <p>Malignant Secondary Tumour <input type="checkbox"/></p>
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<p><b><u>MEDICAL ALERT?</u></b><sup>(9)</sup> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b><u>Check patient's Medical Record for details of any medical alert</u></b></p>	<p><b><u>IS THE PATIENT DIABETIC?</u></b> IDDM <sup>(10)</sup> <input type="checkbox"/> Non-IDDM <input type="checkbox"/></p> <p><b><u>Please complete this section in addition to the Primary Cause of Amputation</u></b></p>						
<p><b><u>EXPECTED DATE OF FIRST VISIT TO PROSTHETICS SERVICE CENTRE</u></b><sup>(11)</sup>:</p> <p>Proposed date of discharge: ..... To permanent address as entered above? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If 'No', insert new address: .....</p>							

**PROSTHETICS SERVICE OFFICE USE ONLY**

Prosthetics Service Unit No: ..... Health Board of Residence: .....

<b>Name:</b>	<b>DoB:</b>
<b>RELEVANT MEDICAL HISTORY</b> (Including pre- and post-operative history. Continue on a separate sheet if necessary):	
.....	
.....	
<b>RELEVANT PATIENT INFORMATION: N.B. Patient weight information is mandatory. Items in <i>italics</i> are optional</b>	
<b>Patient's Weight<sup>(12)</sup>:</b> ... <b>Static</b> <input type="checkbox"/> <b>Increasing</b> <input type="checkbox"/> <b>Decreasing</b> <input type="checkbox"/>	
<i>Dominant Side (only required for upper limb amputee):</i> <i>Left</i> <input type="checkbox"/> <i>Right</i> <input type="checkbox"/>	
<i>Occupation:</i> .....	<i>Hobbies:</i> .....
<i>Accommodation<sup>(13)</sup>:</i> .....	
<b>WHEELCHAIR</b>	
<b>Has wheelchair assessment/prescription been completed?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>Ability to Transfer:</b> Unable <input type="checkbox"/> With assistance <input type="checkbox"/> With walking aids <input type="checkbox"/> Independent <input checked="" type="checkbox"/>	
<b>REHABILITATION PROGRESS:</b> Please complete a <b>Therapy Update Sheet</b> and send it <b>with</b> this form if a Prosthetics Service appointment is likely to be required/arranged within 7 days. If the appointment is more than 7 days away, please send an Update Sheet with the patient or fax a copy to the centre (Fax No. 0131 536 4840) to arrive prior to the appointment.	
<b>OTHER RELEVANT INFORMATION/TREATMENT</b>	
.....	
<b>TRANSPORT REQUIREMENTS<sup>(14)</sup></b>	
Own transport <input type="checkbox"/>	Ambulance:    2-man <input type="checkbox"/> 1-man <input type="checkbox"/> Ambulance Car <input type="checkbox"/>
Other relevant details: .....	
<b>COMMUNICATION</b>	
Does the patient have communication difficulties?    No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, patient should be accompanied at <b>each</b> visit Slightly deaf but no significant disability.	
Does the patient require translation services?    No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> If yes, state language	
<b>KEY CONTACTS</b>	
<b>Inpatient Physiotherapist:</b> Name: .....	 : .....
<b>Outpatient Physiotherapist:</b> Name: .....	Centre: .....  : .....
<b>Occupational Therapist:</b> Name: .....	Centre: .....  : .....
<b>Prosthetist<sup>(15)</sup>:</b> Name: .....	Centre: .....  : .....
<b>REFERRAL SOURCE</b> Print Name: .....	
Job Title: .....	
Signature: ..... Date: _: .....	
 : .....	

PLEASE SEND THE COMPLETED FORM TO:

Prosthetics Service, Westmarc, Queen Elizabeth University Hospital, 1345 Govan Road, Glasgow, G51 4TF  
Telephone: 0300 790 0129  
Email: westmarc@ggc.scot.nhs.uk

An electronic (PDF) version of this form is available – please contact the Prosthetics Service Manager at the above address  
This form was developed by the Prosthetics Service Group of the Scottish Rehabilitation Technology Services Provider Forum (ScotRet)