**\*ALL FIELDS NEED TO BE COMPLETED\***

**Specialist Prosthetics Referral Form – Updated Jan 2025**

|  |  |
| --- | --- |
| **Patient Details:** | **GP Details:** |
| Name: |  | Name: |  |
| Address: |  | Address: |  |
| DOB: |  | **Next of Kin Details:**  |
| NHS Number: |  | Name: |  |
| Male/Female: |  | Relationship to Patient: |  |
| Phone Number: |  | Phone Number: |  |

|  |  |
| --- | --- |
| **Details of Amputation:**Level(s)/ Side(s)/ Op date(s): Elective or Emergency? |  |
| **Primary Cause of Amputation**:Ischaemia/Infection/Trauma/Tumour/Congenital/ Chronic Pain etc. |  |
| **History Leading to Amputation:**Previous Surgeries/ Procedures to salvage limb? Infection? Pain?  |  |
| **Details of Operation:**Relevant Post-operative Details (ITU stay?):Closure Used – Sutures/Staples/Glue/Delayed:**Operating Surgeon:** |  |
| **Consultant in Charge:** |  |
| **Hospital and Ward:** |  |
| **Allergies:**(Medication/ Food/ Material i.e. Latex) |  |
| **Current Medications:** (Repeat Prescription Medication) |  |
| **Contralateral Limb Details:**Circulation Issues/Claudication?Strength/ ROM/ Sensation?Prior Amputations/Procedures/Surgery/Wounds?Current Podiatry input? (Location/Frequency):  |  |
| **Medical History:** Diabetes?Heart/Lung Conditions?Neurological Conditions?Joint/Spine/MSK Issues?Previous Surgeries? Continence – Stoma? Catheter? |  |
| **Cognition:**Any Issues Detected? / Diagnosis of Dementia?Formal Tests Completed (MoCA/AMTS)?Capacity to Make Decisions? |  |
| **Other Relevant Details:**Smoker? /Alcohol Use? / Other Substances?Hearing Difficulties? / Sight Difficulties?Mental Health Difficulties? |  |
| **Previous Mobility:** (Prior to Amputation & Prior to Onset of Limb Issues)Mobility Aid? / Distance Walked? /Falls?Hobbies? / Working? / Driving? |  |
| **Home Environment:**Type of Property (House/Bungalow/Flat/Caravan)Living alone or with someone?Outside Access – ramp/steps?Inside Access - stairs? stair lift? Downstairs Living? / Carers? |  |
| **Wound Status:**Healed/Unhealed?Dressing on? – Simple/PICO/VAC?Any Infection or Dehiscence? |  |
| **Therapy Details:**Completing Transfers / Exercises?Motivation / Limitations / Contractures?Wheelchair Provision? |  |
| **BLARt score** (see appendix): |  |
| **Pressure Risk Assessment:**Purpose T score & Date Completed:Current Pressure Ulcers & Grade:  |  |
| **Pain:**Type - Residual Limb? / Phantom? / MSK?Pain score (VAS):Using Pain Relief? / Limb Massage? |  |
| **Discharge Plans:**Destination / Date Planned for Transfer:  |  |
| **Any Further Comments:** |  |
| **Details of Referrer:** |
| Name:  |  |
| Position: |  |
| Phone/Bleep number:  |  |

**PLEASE EMAIL THE REFERRAL FORM AND OP NOTE TO:**

livewell.plymouthprosthetics@nhs.net

Any questions please email or call: 01752 434200

**PLEASE NOTE:** Referral forms that do not contain enough information will be rejected and sent back to the referrer to complete in full.

**Appendix:**

**BLARt Score:**

