

AMPUTEE REFERRAL FORM

- Post-Op Limb Protector
 Shrinker Sock
 New Prosthesis
 Patient is aware of this referral?
 Yes
 No

PATIENT INFORMATION

Gender: Male Female

Name: _____ Date of Birth: _____

Email: _____

Mobile Phone: _____ Alternative Contact: _____

AMPUTATION DETAILS

Side of Amputation: Left Right Bilateral

Amputation Type:

- | | | |
|---|---|---|
| <input type="radio"/> Partial Foot | <input type="radio"/> Shoulder disarticulation | <input type="radio"/> Unknown/Other <i>(Please Specify)</i> |
| <input type="radio"/> Symes/ankle disarticulation | <input type="radio"/> Trans humeral | _____ |
| <input type="radio"/> Transtibial | <input type="radio"/> Trans radial | _____ |
| <input type="radio"/> Knee disarticulation | <input type="radio"/> Wrist Disarticulation | _____ |
| <input type="radio"/> Transfemoral | <input type="radio"/> Partial Hand | _____ |
| <input type="radio"/> Hip Disarticulation | <input type="radio"/> Pre-amputation assessment | _____ |

Cause of Amputation:

- | | | |
|---|----------------------------------|---|
| <input type="radio"/> Vascular | <input type="radio"/> Tumour | <input type="radio"/> Unknown/Other <i>(Please Specify)</i> |
| <input type="radio"/> Injury/trauma | <input type="radio"/> Diabetes | _____ |
| <input type="radio"/> Infection | <input type="radio"/> Neurogenic | _____ |
| <input type="radio"/> Congenital deficiency/deformity | | _____ |

REFERRER'S DETAILS

Name: _____

Date: _____

Date of amputation: _____

Hospital: _____

Surgeon: _____

Please attach patient face sheet with demographics

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