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NHS Trust

FUNCTIONAL ELECTRICAL STIMULATION (FES) REFERRAL FORM

To the Referrer
Please complete sections 1 – 7 overleaf. Please ensure that the patient's GP completes the boxes below before sending it to the Gait Laboratory. For summary information on our assessment criteria and clinical pathway, please refer to the appendix on page 4 of this form.

To the GP
Please complete below with your details and sign to confirm that you are happy for us to proceed with the FES assessment and follow up treatment if indicated. If you require any further information on FES, please contact us at the address above.

Patient Details	
Full Name (forename, surname):	Date of Birth:

GP Details	
Name:	
Address:	
Postcode:	
CCG:	
Signature of GP:	Date:

When completed, please return this form to the Gait Laboratory at the address above

Functional Electrical Stimulation (FES) Referral Form

1. Patient Data	
Full Name (forename, surname):	Date of Birth:
Full Address: Postcode:	Contact Telephone Number: NHS Number:
If referral is for a child, please also supply parent / carer name below:	
Full Name:	Relationship to Child:

2. Details of Referrer	
Name of Referrer:	Date Form Completed:
Position:	
Address:	
Telephone Number:	
Email Address:	

3. Reason for Referral
Patient's problems to be addressed:

4. Type of FES Assessment and Treatment (if appropriate) Requested	
Gait Assist: ☐	Upper Limb: ☐
Other:	

Patient Name (forename, surname):	**Date of Birth:**

5. Goals for FES Intervention

6. Clinical Data
Diagnosis:
Date of onset:
Orthoses/splints/walking aids used:
Previous interventions with dates (e.g. Botulinum Toxin injections/splints tried):

7. Additional Information	
Expected date of any planned interventions: *(for example: relevant surgery; orthotics or Botulinum Toxin injections)*	
Approximate Time Scales for Appointments We aim to undertake the assessment within 8 weeks of receiving the referral If suitable, we aim to commence treatment with FES within 8 weeks of the assessment appointment	
Please add any further information that you believe will be helpful for the assessment:	

This form MUST be completed by the referrer and the front sheet signed by the patient's GP

Appendix – Electrical Stimulation Referral Guidelines

Assessment

At the assessment we will undertake the checks outlined below. It would be helpful if referrers could undertake a preliminary review of these. If any issues/concerns arise that you would like to discuss further, please contact us using the details given on the first page.

- Are the muscles of interest innervated? If not then stimulation with the equipment we have is unlikely to be helpful.
- Is there adequate joint range of movement within levels of comfort? For example, for gait assist it should be possible to achieve a passive plantargrade position of the foot with the knee extended.
- Is compliance likely to be an issue? For example, will the patient/carer understand the aims of the intervention, be able to set up the stimulation equipment, and use it safely?
- Is sensation affected in the area to be stimulated? In particular if hypersensitive this may prevent stimulation being tolerated.
- Is there adequate skin condition as surface electrodes will be used, e.g. not broken where the electrodes will be placed?
- If there is evidence of epilepsy, is it controlled?
- If there is evidence of cardiac arrhythmias, are they controlled?
- If there is use of an implanted electronic device, e.g. demand pacemaker, then guidance on the suitability of stimulation from an appropriate clinician would be required.
- If there is evidence of autonomic dysreflexia we would not stimulate without discussion with an appropriate clinician.
- If the patient is/is likely to be pregnant, then we would not proceed.
- If the patient has a cancerous tumour in the area to be stimulated, then we would not proceed as stimulation may lead to tumour growth due to increased blood flow.
- If there is exposed (orthopaedic) metal fixtures in the area to be stimulated, then we would not proceed. Joint replacements are not normally a contraindication.

Summary of clinical pathways

Upper limb stimulation

Assuming the assessment is positive, we normally provide a 3 month block of treatment with reviews at 1 week (post setup), 7 weeks and 13 weeks. We would normally encourage patients to stimulate twice a day, starting from 5 minutes and increasing to 15-30 minutes for each session, and if appropriate to try and use part of the intervention time to combine the stimulation with functional movements. Outcome measures (dependent on the referral and the ability of the patient) are normally collected at setup, and the 7 and 13 week reviews. At the 3 month point we normally discontinue treatment for 3 months and then reassess (including outcomes measures), and then discuss with the patient/clinical team whether further intervention is required. We encourage the referrer to attend the assessment and to support use of the stimulation by/with the patient.

Lower limb stimulation (usually gait assist)

Assuming the assessment is positive, we would provide the stimulator and clinical/technical support for as long as we and the patient feel that stimulation is being effective. Reviews are normally held at 1 week, 7 weeks, 3 months and 6 months post setup, and then every 6 months. At the reviews outcome measures are collected as appropriate. We encourage the referrer to attend the assessment and to support use of the stimulation by/with the patient.

Document Review Date: 01/05/2015