St George's Healthcare NHS
NHS Trust

ROEHAMPTON REHABILITATION CENTRE

IN*/OUT*-PATIENT PROSTHETIC REHABILITATION REFERRAL

*Delete as appropriate. If not deleted, will assume out-patient referral.

PLEASE ENSURE ALL SECTIONS OF THE FORM ARE COMPLETED

TO: Dr S. Sooriakumaran FRCS FRCP
Consultant in Rehabilitation Medicine
Roehampton Rehabilitation Centre
Roehampton Lane
London SW15 5PN
Tel: 020 8487 6800
Fax: 020 8487 6805

FROM: **Consultant** _____
Hospital: _____
Address: _____
_____
Ward: _____
Contact No. _____

1 To be completed by Medical Staff

Patient's Name		Date of Hospital Admission	
		Date of Amputation	
Male/Female	Mr/Mrs/Miss/Ms	Date of Hospital Discharge	
Address		Discharge Address (if different)	
Post Code		Post Code	
Tel No		Tel No	
NHS No		Occupation	
Date of Birth		Single/Married/Divorced/Widowed/Partner	
GP's Name		Name of Next of Kin	
Address		Address	
Post Code		Post Code	
Tel No		Tel No	

Is the patient well enough to attend the Roehampton Rehabilitation Centre? Yes/No

Date of Amputation | | | | If not yet, when | |

	Lower Limb	Upper Limb
Amputation Level	L _____	L _____
	R _____	R _____

Amputation Technique (tick where appropriate)	Myoplastic		Simple Flaps		
	Skew Flaps		Other		

Cause of Amputation

Primary	Revision

P.M.H.
+
H.P.C.

Drug Treatment

Height ☐ **Weight** ☐

Visual impairment YES/NO **Interpreter required YES/NO**

Hearing impairment YES/NO **Language** _____

2 To be completed by Nursing Staff

Condition of Stump:	**HEALED**	**Y**	**NOT HEALED**	**infected**
		N		**clean and granulating**

Phantom Pain YES/NO **Stump Pain YES/NO**

Diabetic YES/NO **Type 1** ☐ **Type 2** ☐

Smoker YES/NO – gave up when _____ **Alcohol** _____

MRSA YES/NO **Date of last screen** .....

Continence	**CONTINENT**	**URINARY INCONTINENCE**	**FAECAL INCONTINENCE**
Pressure Care	**Waterlow Score** ☐	**Using airless mattress Y/N**	
Pressure Sore	**Y/N if Yes: infected/clean and granulating**		

Condition of remaining leg _____

Chiropody referral/care **YES/NO**

Any other nursing information.

3 To be completed by Therapists

Lower Limb

Therapy Information – For upper limb amputee please attach Therapy report.

	Yes	No
Is the patient safe and independent in using wheelchair?	☐	☐
Is patient independent in washing and dressing?	☐	☐
Can patient transfer independently from any surface using a standing pivot transfer?	☐	☐

If not please state method of Transfer _____

Is patient able to push up from sitting in wheelchair to stand independently in parallel bars?	☐	☐
Has the patient starting using an EWA within parallel bars.	☐	☐
Does the patient have a Hip Flexion Contracture greater than 25°?	☐	☐
Is the patient cognitively unimpaired?	☐	☐
Has wheelchair been ordered?	☐	☐

If Yes, type _____

Has home visit been carried out?	☐	☐

Please supply copy report. If unable, please attach summary of social or housing situation.

Contacts

	Report enclosed	
Physiotherapy name and contact/bleep		
_____	☐	☐
Occupational Therapy name and contact/bleep		
_____	☐	☐
Psychology name and contact		
_____	☐	☐

Any other relevant information from the referring team:

Please indicate that if admitted but subsequently does not respond to intensive rehabilitation, within a period of 2/52, the referring hospital will take the patient back.

I agree to accept the patient back if not considered appropriate for the amputee rehabilitation service or when he/she has not achieved their optimal functional level; or when optimal function is achieved but social problems are preventing discharge home.

Name of Consultant: **Name: (Print)**

Signature: **Date:**

Hospital Transport Required:

Ambulance 1 Man	☐	**Hospital Car**	☐	**Escort Required YES/NO**
Ambulance 2 Man	☐	**None**	☐	

For Centre completion on initial assessment.

Prosthetic rehabilitation commenced ☐

Referred for review ☐

NON LIMB WEARER ☐

Admission to ward ☐

Waiting list for admission ☐