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 Vijay Kolli
Consultant in Rehabilitation Medicine
Roehampton Rehabilitation Centre
Roehampton Lane
London SW15 5PN
Tel: 020 8487 6030
Email: QMH.amprehabreferrals@nhs.net

FROM:

Consultant:	
Hospital:	
Ward:	
Contact No:	
Bleep:	

1 To be completed by Medical Staff

NHS Number		**Date of Hospital Admission**	
Patient's Name		**Date of Amputation**	
		Date of Hospital Discharge	
Male / Female			
Address		**Discharge Address**	
Post Code		**Post Code**	
Tel No		**Tel No**	
Date of Birth		**Occupation**	
GP's Name			

Single	Married	Divorced	Widowed	Partner

Address		**Name of Next of Kin**	
Post Code		**Post Code**	
Tel No		**Tel No**	

Is the patient well enough to attend the Roehampton Rehabilitation Centre? **YES** ☐ **NO** ☐

	Lower Limb	Upper Limb
Amputation Level	**L**	**R**
	R	**L**

Amputation Technique (mark where appropriate)

Myoplastic	☐	**Simple Flaps**	☐
Skew Flaps	☐	**Other**	☐

Cause of Amputation				
	Primary		Revision	

P.M.H. + H.P.C.	
Drug Treatment	

Height		Weight		
	YES	NO		YES NO
Visual Impairment			Interpreter required	
Hearing Impairment			Language:	

2 To be completed by Nursing Staff

Condition of Stump (mark where appropriate)	HEALED	YES		NOT HEALED	Infected	
		NO			Clean and granulating	

	YES	NO		YES	NO	Units per week
Stump Pain						
Phantom Pain			Alcohol			
Diabetic			TYPE: 1 / 2			
Smoker:			Date given up			
MRSA			Date of last screen			

Continence	CONTINENT			URINARY CONTINENCE		FAECAL CONTINENCE			
Pressure Care	Waterlow Score			Using airless mattress?		YES		NO	
Pressure Sore	YES		NO	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 a wheelchair?		
Is the 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 started using an EWA within parallel bars?		
Does the patient have a Hip Flexion Contracture greater than 25 degrees ?		
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	NAME	CONTACT No.	BLEEP	Report enclosed YES	NO
Physiotherapist:					
Occupational Therapy:					
Psychology:					

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:

Signature:		Date:	