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FUNCTIONAL ELECTRICAL STIMULATION (FES) REFERRAL FORM

To the Referrer
Please complete sections 1 – 7 overleaf and consider the checklist in section 8. Please ensure that the patient's GP completes the boxes below before sending it to the Gait Laboratory. For summary information on our clinical pathway, please refer to section 9.

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:	Gender: Male ☐ Female ☐ NHS Number:
Preferred Contact Telephone Number(s) *(if this is not the patient, please add a justification):*	Name and Relationship to Patient (*if not patient*):

*If referral is for a child, please also supply parent / guardian / carer name below**:***		
Full Name:	Relationship to Child:	Telephone Number:
Is the child known to social services? *(if 'Yes', please add further details to section 7. Additional Information):*		Yes ☐ No ☐

2. Details of Referrer and Support Team	
Name of Referrer:	Date Form Completed:
Position:	
Address: Postcode:	
Telephone Number:	
Email Address:	
Plan for patient follow-up, discharge and/or onward referral:	

Contact details for support team (on-going community or hospital input – further relevant input can be added to section 7. Additional Information):

Name	**Position**	**Address**	**Tel. No.**
	Nurse Specialist		
	Consultant		
	Physiotherapist		
	OT		
	Orthotist		

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

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

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

5. Goals for FES Intervention
If FES has been used before please provide a short summary of use/outcome:

6. Clinical Data
Diagnosis:
Date of onset:
Orthoses/splints/walking aids used: For Gait Assist, describe the walking aids/assistance required for the patient to walk 10 m:
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 18 weeks of receiving the referral If suitable, we aim to commence treatment with FES within 8 weeks of the assessment	
Please add any further information that you believe will be helpful for the assessment:	

8. Assessment Checklist

At the assessment we will undertake the checks outlined below. It would be helpful if you could undertake a preliminary review of these. If any issues arise that you would like to discuss further, please contact us using the details given on the first page.	Yes	No	Not known
Does the patient use an implanted electronic device, e.g. demand pacemaker? If so guidance on the suitability of stimulation will be required from an appropriate clinician.	☐	☐	☐
Is the patient likely to be pregnant? If pregnancy is known or likely, then we would not normally proceed.	☐	☐	☐
Does the patient have a cancerous tumour in the area to be stimulated? If so we would not normally proceed as stimulation may lead to tumour growth due to increased blood flow.	☐	☐	☐
Does the patient have exposed (orthopaedic) metal fixtures in the area to be stimulated? If so we would not proceed. Joint replacements are not normally a contraindication.	☐	☐	☐
For spinal cord injury is there evidence of autonomic dysreflexia? If so we would not stimulate without discussion with an appropriate clinician.	☐	☐	☐
Are the muscles of interest innervated? If not then stimulation with the equipment we have is unlikely to be helpful.	☐	☐	☐
If there is evidence of epilepsy, is it controlled, e.g. no seizures within past 6 months?	☐	☐	☐
If there is evidence of cardiac arrhythmias, are they controlled?	☐	☐	☐
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 reasonable? 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 unaffected in the area to be stimulated? In particular if hypersensitive this may prevent stimulation being tolerated.	☐	☐	☐
Surface electrodes will be used so is there adequate skin condition, e.g. not broken where the electrodes will be placed?	☐	☐	☐
For gait assist FES, can the patient currently take some steps with/without aids?	☐	☐	☐

9. 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 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 12 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.

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