**REFERRAL for NHS Prosthetic Rehabilitation**

**Please ensure all information has been provided. Incomplete referrals will be returned to the referrer, leading to delays for your patient.**

Once **fully** completed and signed send to: Kent and Medway NHS and Social Care Partnership Trust, Specialist Equipment Services, Disablement Services Centre, Medway Maritime Hospital, Windmill Road, Gillingham, Kent ME7 5PA Tel: 01634 833948 E-mail: KMPT.specialistequipmentservices@nhs.net

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| **PATIENT TITLE: MR, MRS, MISS, MS, OTHER (*specify*)** | **PATIENT DOB:** |
| **PATIENT SURNAME:** | **NHS NO:** |
| **PATIENT FORENAME(S):** | **ETHNICITY:** |
| **FIRST LANGUAGE:** | **TELEPHONE NO:** |
| **ADDRESS:****POST CODE:** | **GP NAME:****ADDRESS:****POST CODE:****TELEPHONE No:** |
| **NOK NAME:****NOK ADDRESS:****POSTCODE:****TELEPHONE NO:** | **CONTACT NAME:****CONTACT ADDRESS:****POST CODE:****TELEPHONE NO:** |
| **PROFESSIONALS/SCHOOL/NURSERY/OTHERS INVOLVED IN PATIENT CARE:****NAME:****ADDRESS:****CONTACT TELEPHONE NO:** |

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| **DISABILITIES:** | **MEDICATION:** |

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| **RELEVANT PAST / PRESENT MEDICAL AND SURGICAL HISTORY:****PLEASE ADVISE THE SOUGHT OUTCOME OF THIS REFERRAL, eg cosmestic, counselling, limb fitting etc:** **SOUGHT OUTCOME:** |

|  |  |
| --- | --- |
| **AMPUTATION DETAILS:****AMPUTATION CAUSE:** | **SITE: L LEVEL SURGERY DATE:****SITE: R LEVEL SURGERY DATE:** |
| **CONSULTANT:****HOSPITAL ADDRESS:****POSTCODE:****TELEPHONE NO:** | **WARD NAME:****WARD TELEPHONE NO:****DISCHARGE DATE/PLANS:** |
| **REFERRER DETAILS****NAME: DESIGNATION:****SIGNATURE: CONTACT TELEPHONE NO:****DATE: ADDRESS:** |

Thank you for your referral.

Following clinical triage, the patient will be contacted.

 **©KMPT**