**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](mailto: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:** |

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| **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.

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