**Central Adelaide Local Health Network - Orthotics & Prosthetics**

# ORTHOTICS ASSESSMENT REQUEST

**Name and Address** *(Hospital Label)*

Patient Telephone Number

☐ **UL** ☐ **LL** ☐ **Spinal**

☐ **Bilateral** ☐ **Right** ☐ **Left**

☐ **DM** ☐ **neuropathy**

**Medical / Surgical History**

**Affected Limb ROM / Strength / Mobility:**

**Objectives** *(please select)*

| | | |
|---|---|---|
| Joint Stabilisation | Post Surgical Support | Increase ADLs/IADLs |
| Facilitate Healing | Increase/Decrease ROM | Improve Gait Biomechanics |
| Prevent/Correct Deformity | Decrease Pain | Other …….. |

Referrer Name *(print)*…… Contact number…… Date……

Referrer Signature…… Speciality ……

**Any referrals without sufficient information or have not been signed and dated will be returned to the referrer.**

Please forward to the Orthotic Department

RAH Tel: 1300153853 Fax: 70746247
Email: Health.RAHorthotics&prosthetics@sa.gov.au

TQEH Tel: 82226734 - Fax: 82227138
Email: Health.CalhnOrthotics&Prosthetics@sa.gov.au

| **For Orthotics use only** |
|---|
| **Date referral received** |
| **Date assessed / cast** |
| **Date device fit** |