

## 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](mailto:Health.RAHorthotics&prosthetics@sa.gov.au)

TQEH Tel: 82226734 - Fax: 82227138

Email: [Health.CalhnOrthotics&Prosthetics@sa.gov.au](mailto:Health.CalhnOrthotics&Prosthetics@sa.gov.au)

### For Orthotics use only

Date referral received

Date assessed / cast

Date device fit