Peke Waihanga
Artificial Limb Service

Amputee Referral Form 1

Referral Details

◯ Referral for prosthetic assessment
◯ Referral for pre-amputation assessment
◯ Not referred for prosthetic assessment due to the following reason:

Patient is aware of this referral: ◯ Yes ◯ No

Personal Details

Name:
Date of Birth:
NHI:
Address:

Email:
Home:
Mobile:

Name of next of kin/emergency contact:

GP & Practice:

Gender

◯ Male ◯ Gender diverse
◯ Female ◯ Unknown

Ethnicity

◯ African ◯ NZ European
◯ Asian nfd ◯ Niuean
◯ Chinese ◯ Other Asian
◯ Cook Is. Māori ◯ Other European
◯ European nfd ◯ Other Pacific Peoples
◯ Fijian ◯ Samoan
◯ Indian ◯ Southeast Asian
◯ Latin American ◯ Tokelauan
◯ Māori ◯ Tongan
◯ Middle Eastern ◯ Other Ethnicity:

Language

◯ Interpreter required:

Amputation Details

Amputation Type (Tick all that apply)

Lower Limb Side(s): ◯ Left ◯ Right

◯ Trans tibial (BK)
◯ Trans femoral (AK)
◯ Knee disarticulation
◯ Hip dis-articulation
◯ Ankle disarticulation / Symes
◯ Hemipelvectomy
◯ Partial foot
◯ Partial toes/toes/multiple toes (specify toes):
◯ Proximal femoral focal deficiency (PFFD)

Upper Limb Side(s): ◯ Left ◯ Right

◯ Trans radial (BE)
◯ Trans humeral (AE)
◯ Elbow disarticulation
◯ Shoulder disarticulation
◯ Inter-scapular thoracic
◯ Wrist disarticulation
◯ Partial hand
◯ Partial finger/multiple fingers (specify fingers & level):

Other Side(s): ◯ Left ◯ Right

◯ PDDF/O'Connor Extension
◯ Van Ness/rotationplasty
◯ Unknown
◯ Other:

Cause of Amputation (Tick all that apply)

◯ Congenital ◯ Infection ◯ Tumour
◯ Diabetes ◯ Injury/trauma ◯ Vascular
◯ Other (specify):

Date of Amputation:
Hospital:
Surgeon:

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Amputee Referral Form 2

Infection

Does the patient have a current infectious disease?

◯ Unknown ◯ No ◯ Yes (specify): _____

Relevant Medical History

Conditions

◯ Arthritis ◯ CVA ◯ Impaired hearing ◯ Renal failure
◯ Cardiac disease ◯ Diabetes (Type 1) ◯ Impaired vision
◯ COPD ◯ Diabetes (Type 2) ◯ PVD
◯ Impaired cognition (specify): _____
◯ Other/detail (specify): _____

Dialysis

◯ Peritoneal ◯ HD

Treatment days: _____

Mobility prior to amputation/aids

_____

Discharge Plan

_____

ACC Information (if known)

Date of Injury: _____
Claim Number: _____
Cause of Injury: _____
Case Manager: _____

Referrals made

List any other referrals made (e.g. Peer Support Service):

_____

Referrer's Details

Name: _____
Role: _____
Referring hospital department & ward: _____
Phone: _____
Email: _____
Date: _____

Please fill in all details and email your completed form to one of our centres:

auckland@nzals.co.nz
hamilton@nzals.co.nz
tauranga@nzals.co.nz
wellington@nzals.co.nz
christchurch@nzals.co.nz
dunedin@nzals.co.nz