Peke Waihanga
Artificial Limb Service

Please fill in all details and email to:
Auckland@nzals.co.nz
Hamilton@nzals.co.nz
Tauranga@nzals.co.nz
Wellington@nzals.co.nz
Christchurch@nzals.co.nz
Dunedin@nzals.co.nz

amputee referral form 1

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

Patient is aware of this referral? ◯ Yes ◯ No

personal details

◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other

Name

Date of birth

NHI

Address

Email

Home phone

Mobile phone

Work phone

Alternative contact

Gender

◯ Male ◯ Female ◯ Gender diverse ◯ Unknown

NZ resident ◯ Yes ◯ No

Ethnicity

◯ Africa
◯ Asia
◯ Australia
◯ China
◯ Cook Island Maori
◯ Europe
◯ Fiji
◯ Great Britain
◯ Maori
◯ Middle East
◯ New Zealand European
◯ North America/Canada
◯ Unknown/Other*
◯ Other Pacific
◯ Samoa
◯ South America
◯ Tonga

*Please specify

Language

Interpreter required ◯ Yes ◯ No

Occupation

GP and practice

amputation details

Amputation type

◯ Partial toe/toe/toes
◯ Partial foot
◯ Symes/ankle disarticulation
◯ Trans tibial
◯ Through knee
◯ Trans femoral
◯ Hip disarticulation
◯ Hemi-pelvectomy
◯ Partial finger/finger/multiple finger
◯ Partial hand
◯ Wrist disarticulation
◯ Trans radial
◯ Elbow disarticulation
◯ Trans humeral
◯ Shoulder disarticulation
◯ Interscapular thoracic
◯ Unknown/Other*
◯ Pre-amputation assessment
◯ PFFD/O'Connor extension
◯ Van Ness rotation/rotationplasty

*Please specify

Side of amputation ◯ Left ◯ Right

Cause of amputation

◯ Vascular
◯ Injury/trauma
◯ Infection
◯ Congenital deficiency/deformity
◯ Other*
◯ Neurogenic
◯ Tumour
◯ Diabetes
◯ Pre-amputation assessment
◯ Orthotic

*Please specify

Date of amputation

Hospital of amputation

Surgeon

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amputee referral form 2

Does the patient have a current infectious disease?
◯ Yes* ◯ No ◯ Not known
*Details

relevant medical history

◯ Cardiac disease
◯ Renal failure
◯ CVA
◯ PVD
◯ T1 diabetes
◯ T2 diabetes
◯ Arthritis
◯ COPD
◯ Impaired hearing
◯ Impaired vision
◯ Impaired cognition

Other/detail

Mobility prior to amputation/aids

Discharge plan

acc information

Date of injury

Claim number

Nature if injury

Case manager

ACC branch

peer support services

Was the patient referred to Peer Support Services while under your care?
◯ Yes ◯ No

Did the patient accept receiving Peer Support?
◯ Yes ◯ *No

*Details

Date of referral

referrer's details

Name

Hospital

Phone

Email

Date

Signature