Peke Waihanga
Artificial Limb Service

Amputee Referral Form 1

Referral Details

◯ Referral for prosthetic assessment

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

Patient is aware of this referral: ◯ Yes ◯ No

Does the patient consent to Peke Waihanga accessing relevant hospital information: ◯ No ◯ Yes

Personal Details

◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other:

Name:

Date of Birth: NHI:

Address:

Email:

Home:

Mobile: Work:

Alternative contact:

Gender

◯ Male ◯ Gender diverse

◯ Female ◯ Unknown

NZ Resident

◯ No ◯ Yes

Ethnicity

◯ Africa ◯ Māori

◯ Asia ◯ Middle East

◯ Australia ◯ New Zealand European

◯ China ◯ North America/Canada

◯ Cook Island Māori ◯ Other Pacific

◯ Europe ◯ Samoa

◯ Fiji ◯ South America

◯ Great Britain ◯ Tonga

◯ Unknown/Other (please specify below):

Language:

Interpreter required: ◯ No ◯ Yes

Occupation:

GP & Practice:

Amputation Details

Amputation Type

◯ Toe/Partial toe/Toes

◯ Partial foot

◯ Symes/Ankle disarticulation

◯ Trans tibial

◯ Through knee

◯ Trans femoral

◯ Hip disarticulation

◯ Hemi-pelvectomy

◯ Finger/Partial finger/ Multiple fingers

◯ Partial hand

◯ Wrist disarticulation

◯ Trans radial

◯ Elbow disarticulation

◯ Trans humeral

◯ Shoulder disarticulation

◯ Interscapular thoracic

◯ Pre-amputation assessment

◯ PDDF/O'Connor Extension

◯ Van Ness rotation/ rotationplasty

◯ Unknown/Other (please specify below):

Side of amputation

◯ Left ◯ Right

Cause of Amputation

◯ Vascular

◯ Injury/trauma

◯ Infection

◯ Congenital deficiency/ deformity

◯ Neurogenic

◯ Tumor

◯ Diabetes

◯ Pre-amputation assessment

◯ Orthotic

◯ Other (please specify below):

Date of Amputation:

Hospital of Amputation:

Surgeon:

Peke Waihanga
Artificial Limb Service

Amputee Referral Form 2

Infection

Does the patient have a current infectious disease?

◯ Not known ◯ No ◯ Yes (please specify below):

ACC Information

Date of Injury:

Claim Number:

Nature of Injury:

Case Manager:

ACC Branch:

Relevant Medical History

Conditions

- ◯ Cardiac disease
- ◯ Renal failure
- ◯ CVA
- ◯ PVD
- ◯ T1 Diabetes
- ◯ T2 Diabetes
- ◯ Arthritis
- ◯ COPD
- ◯ Impaired hearing
- ◯ Impaired vision
- ◯ Impaired cognition
- ◯ Other/detail (please specify below):

Mobility prior to amputation/aids

Discharge Plan

Peer Support Services

Was the patient referred to Peer Support Services while under your care?

◯ No ◯ Yes

Did the patient accept receiving Peer Support?

◯ No* ◯ Yes

* Details

Date of Referral:

Referrer's Details

Name:

Hospital:

Phone:

Email:

Date:

Signature:

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