Rehabilitation and Continuing Care Program

Referral to Amputee Clinic

Telephone: (709) 777-6470
Fax (709) 777-6725

Name:

HCN:

Date of Birth:

Address: ______________________________

Telephone No:______________________

Alternate Contact & Telephone No: ______________________________

Diagnosis:
- ☐ Above Knee Amputation
- ☐ Below Knee Amputation
- ☐ Knee Disarticulation Amputation
- ☐ Symes
- ☐ Other: ______________________________

Limb:
- ☐ Right
- ☐ Left
- ☐ Bilateral
- ☐ Partial Foot

Date of Surgery: DD/MONTH/YYYY Date of Discharge: DD/MONTH/YYYY

Surgeon: ______________________ Family Physician: ______________________

Cause of Amputation: ______________________________

Status of Remaining Limb: ______________________________

Past Medical History: ______________________________

Pre-Amputation Level of Mobility: ______________________________

Reason for Referral: ______________________________

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Physician's Name:______________________ Date: DD/MONTH/YYYY

Physician's Signature: ______________________