Rehabilitation/Continuing
Care Program

Referral For Prosthetic Assessment

Name:

HCN:

Date of Birth:

Prosthetics/Orthotics Department
Telephone: (709) 777-6470 Fax: (709) 777-6725

Referral from: ☐ St. Clare's Unit ☐ HSC Unit

Address: ____________________

Telephone No: ____________________

Alternate Contact & Telephone No: ____________________

Diagnosis:
- ☐ Above Knee Amputation
- ☐ Below Knee Amputation
- ☐ Knee Disarticulation Amputation
- ☐ Symes
- ☐ Partial Foot
- ☐ Other: ____________________

Limb:
- ☐ Right
- ☐ Left
- ☐ Bilateral

Date of Surgery: DD/MONTH/YYYY

Surgeon: ____________________ Family Physician: ____________________

Cause of Amputation: ____________________

Comorbidity: ____________________

Funding Agency: ☐ Client Pay ☐ Insurance ☐ Social Services ☐ Other: ____________________

Physiotherapist & Telephone Number: ____________________

Occupational Therapist & Telephone Number: ____________________

Additional Comments: ____________________

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

Physician' s Signature: ____________________