UHN West Park Healthcare Centre

West Park | Altum Health - Prosthetics & Orthotics Department Referral Form

Please complete to the best of your ability. If information is located in EPR, please note. Please attach current medication list and supporting documentation.

Please note that outpatients need to be seen in Ambulatory Amps Clinic prior to see prosthetics. Please call 416-243-3600 x32724 to schedule an appointment.

Fax: 416-243-3669 Email: WP-AltumPOInfo@UHN.ca Phone: 416-243-3614

Referral Source ***Date of Referral Receipt*** *(completed by P&O)*:

- Referring Department/Unit: _____
- Referring Clinician (Name/Title): _____
- Contact Number: _____ Fax: _____

Patient Information

- Full Name: _____ DOB: _____
- Health Card #: _____ Version: ____
- Address: _____
- Phone: _____ Alternate: _____
- Email Address: _____
- Primary Language: _____ Interpreter required: Yes ☐ No ☐

Funding Information

☐ Insurance (specify): _____
☐ MVA (Motor Vehicle Accident)
☐ WSIB
☐ ODSP
☐ OW
☐ Other

Case Manager Name: _____
Case Manager Phone #: _____
Case Manager Address: _____
Copy of current benefit statement required

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Rehabilitation Goals (*To be completed by referring team with patient input)*

- Patient's overall rehab goals: _____
- Patient's prosthetic-specific goals: _____

Pre-Assessment Readiness

Footwear: *(fill in if known)*
☐ Suitable footwear available
☐ Not available – on order / will purchase
☐ Family to bring (date: _____)

Discharge & Backup Mobility Plan:
Housing: ☐ existing home ☐ moving to new home ☐ moving to assisted living/LTC
Mobility aids: ☐ own wheelchair ☐ rental wheelchair ☐ crutches ☐ walker
☐ Other: _____

Family Support Needs:
☐ Family member required (financial discussion / care commitment)

Name: _____ Contact: _____

Summary of Therapy Progression *(to be completed by PT/OT)*:

- Participation/compliance: _____
- Learning/anxiety: _____
- Transfers/hopping/standing time: _____
- Anticipated **K level**: _____
- Independence & challenges: _____

Dialysis Schedule (if applicable): _____

Anticipated Limb Readiness Date (casting/fitting): _____

Additional Information

- Relevant medical/psychosocial/ cognitive notes: _____
- Anticipated discharge date (if inpatient): _____

Referring Clinician Signature/Stamp

Signature: _____ Date: _____