

Medway Maritime Hospital - Orthotics Referral Form

*Source of referral: Consultant ☐ GP ☒ AHP (Hospital based) ☐ *Community ☐ Other ☐

Please specify _____

*Parallel referral ☐ Patient requiring orthotics prior to consultant intervention
(Stroke and CAS team use only)

*Patient's Surname Margery *First Name Katrina

*Address Wing Road Leysdown-On-Sea

Sheerness Kent *Postcode ME12 4QR

*Telephone No _____ Mobile No 07851395901 Work Number _____

400
067
*NHS Number 0514 D.O.B 24-May-1967 *PAS/Case Note Number Where Available _____

*Inpatient YES/NO *Hospital _____ *Ward _____ *Extension No _____

Diagnosis – Aim of Orthoses Management

Patient suffering with hair loss due to stress, previous history of alopecia . Would like to be reviewed for the possibility of having a wig.

*Referrer's Details: PLEASE NOTE: This referral will not be processed unless all the required details are entered below. COMPLETE all sections to avoid delay in treatment. INCOMPLETE forms will be returned.

*NAME	Dr F Igwe	*POSITION	GP
*DEPARTMENT/PRACTICE ADDRESS			
St Georges Medical Centre, St Georges Avenue, Sheerness, Kent, ME12 1QU			
*TEL NO	01795 582880		
*EMAIL			
*DATE	19 January 2018		
*SIGNATURE	Dr F Igwe		

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Location Area 5 Outpatients,
Level 2, Purple Zone

Opening Times Monday to Friday
09.00 – 17.00 hrs