**FUNCTIONAL ELECTRICAL STIMULATION FOR UPPER &**

**LOWER LIMB**

# **SELF-REFERRAL FORM FOR PRIVATE TREATMENT**

**Please return this referral by E mail or post to:**

**Email:** **referrals@odstockmedical.com or sft.oml.patientsupport@nhs.net**

**Post:** Referral Team, Odstock Medical Limited Laing Building, Salisbury District Hospital, Salisbury

Wiltshire, SP2 8BJ

**Examples of how FES can be used:**

For FES referral criteria please see: <https://odstockmedical.com/patients/patients-referral-options/>

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| **Upper Limb** | **Lower Limb** |
| Improving upper limb function  Shoulder subluxation (pain and management of)  Maintaining range of movement  Muscle strengthening  Reducing tone/spasticity in the arm and hand | Drop foot correction  Hip/knee flexion in gait  Improving push off  Muscle strengthening  Maintaining muscle bulk |

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| **Patient Name:** |  | | |
| **­­Address & Postcode:** |  | | |
| **Date Of Birth:** |  | **NHS No:** |  |
| **Telephone:** |  | **Mobile:** |  |
| **Email:** |  | | |
| **G.P. Name & Address Including Postcode:** |  | | |

**In order for us to process your referral, we may be required to contact your GP or Consultant to request additional clinical information. If you are in agreement, please authorise us to do so by ticking the box:**

If funding is available in your local area we will approach the local NHS Funding panel on your behalf, if you are in agreement. **If you are in agreement, please authorise us to do so by ticking the box.**

Are you aware that this treatment may not be routinely funded by your local NHS?

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| **Please indicate the type of FES treatment you require and the desired outcomes from the treatment. If you have had a trial of FES, please give details including the length of time they used it for:**  **Lower Limb ☐ Upper Limb** **☐ Other** **☐** |
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FES is usually only appropriate for neurological conditions of the brain or the spinal cord. Please indicate which condition the patient has or add the name of the condition.

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| **Stroke** | **Multiple Sclerosis (MS)** | **Head injury** | **Cerebral Palsy (CP)** |
| **Transverse Myelitis** | **HSP** | **Parkinson’s (PD)** | **Spinal Cord Injury** |
| **Other:** | | | |
| **If a spinal cord injury, please indicate the level and type:**  **Spinal Level: Complete  Incomplete** | | | |
| **How long has the patient had this condition?** | | | |

FES is unlikely to work if the nerve that connects the spinal cord to the muscle is damaged. This can happen in the following cases/diseases:

**Polio Guillen-Barre Syndrome Peripheral Nerve Injury Motor Neurone Disease Prolapsed lumbar disc Peripheral Neuropathy**

**Spinal Cord injuries below T12**

If you have a condition which is not on either list, or you would like to discuss whether FES could be suitable for you, then please contact us to speak to a Clinician.

**Telephone:** 01722 439560 **or Email:** referrals@odstockmedical.com.

**Please complete the following screening questions.**

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| 1. **Do you have a pacemaker or other electronic implant? YES**  **NO ☐**   **If yes please provide details:** |
| 1. **Do you have any other heart condition? YES**  **NO ☐**   **If yes please provide details:** |
| 1. **Do you have breathing difficulties? YES**  **NO ☐**   **If yes please provide details:** |
| 1. **Do you have epilepsy? YES**  **NO ☐**   **If yes is the epilepsy controlled? YES**  **NO ☐**  **Approximate date of last seizure:** |
| 1. **Are you pregnant or think you may be pregnant? YES**  **NO ☐** |
| 1. **Do you have any skin conditions or allergies? YES**  **NO ☐**   **If yes please provide details:** |

For lower limb and drop foot please tell us about your level of mobility:

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| 1. Can you sit to stand independently? YES  NO ☐ |
| 1. Can you walk 5m or further with appropriate aids or assistance? YES  NO ☐   Please indicate how far you can walk without taking rest: |
| 1. If you use aids or assistance, please state what you use: |
| 1. If AFOs are not currently used, please state if they have been used in the past and why they are no longer used? |

**Please add below any further information that you feel may be relevant. Please say if you have any communication needs or have a family member / carer that is the main point of contact.**

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**Where did you originally hear about us?**

Website Publication

Word of mouth recommendation Healthcare Professional

Social media Event

Patient Group, e.g. MS Society Other (please specify)

**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For an explanation regarding what personal information we collect about the patient, how and why we process (collect, store, use and share) their personal information, their rights in relation to their personal information and how to contact us to make a complaint, please see our Privacy Notice which can be found at [www.odstockmedical.com](http://www.odstockmedical.com).