MANCHESTER LIMB RECONSTRUCTION

Referring Consultant:

Referring Hospital:

Contact Number for Referring Team: Mobile Bleep

Date of Referral:

Patient Name:

Patient Date of Birth:

Reason For Referral:

Mechanism of Injury/History including previous surgery:

Past Medical History:

Allergies:

Medications:

Smoker: Yes No

Other Information/Comorbidities:

Swabs for MRSA/CPE: Yes No

PLEASE FAX THIS BACK TO 0161 276 8006

IF YOUR PATIENT HAS AN ACUTE FRACTURE, PLEASE SPEAK TO THE REGISTRAR ON CALL AS WELL TO INFORM THEM OF THE REFERRAL