



# The Leeds Teaching Hospitals



NHS Trust

## Obstetrical Brachial Plexus Palsy Referral

Please provide the following details for all patients



I would like the following patient to be seen by Prof. Kay  Mr. Saeed  Miss Bourke

### Referrer's Details

Name:  
Department:  
Hospital:

Post code:  
Contact No.  
Fax No.

Page No.

### Patient Details

Name:  
Address:

Postcode:  
Contact. No:  
Date of Birth:  
Age at the time of referral:      weeks      days

### Clinical Details:

Birth weight:      Kgs      Shoulder dystocia:       Y  N  
Assisted delivery:       Y  N      Bernard Horner's sign:       Y  N  
Apgar score at birth:      Apgar score at 5 mins:  
Hemi-diaphragm paralysis:       Y  N

Post natal recovery of affected arm (please comment on posture and active movement of the upper limb):

Other medical conditions:

Interpreter required? Y  N  Language

Referrer's signature:

Date of referral:

**Please Fax this referral form to 0113 2066423**

**LTHT Admin section:** Date referral received in LTHT

Child < 12 weeks appointment booked with specialist physiotherapist

Child ≥ 12 weeks appointment booked for urgent consultant clinic