

**American Amputee Foundation
Information and Referral Form**

Client/Patient Name:

Please print or type

Client/patient address:

Date of referral: _____

Phone number: (____) _____ Date of birth: _____ Present age: _____

Marital status: _____ Date of amputation: _____

Cause of amputation (disease or trauma): _____

Level of amputation: _____

AE - above elbow BK - below knee HP - hemipelvectomy
BE - below elbow AK - above knee HD - hip disarticulation
SD - shoulder disarticulation KD - Knee disarticulation Symes/partial foot

Was the amputation work related: _____ Was the amputation service related: _____

Name of referral facility: _____

Name of referral counselor: _____

Phone number of counselor: _____

PERMISSION FOR RELEASE OF INFORMATION

I hereby grant the above facility permission to release the above information to the American Amputee Foundation for information and referral purposes. I understand that by doing so, the Foundation will send further educational information to me regarding contacts, self-help, and prosthetic vendors/facilities.

Client/patient's signature (or family member)

Please return or FAX this form to:

American Amputee Foundation
P.O. Box 94227
North Little Rock, AR 72116
FAX: 501-835-9292
PHONE: 501-835-9290