

**Special Seating Service**

Douglas Bader Rehabilitation Unit, Queen Mary’s Hospital,

Roehampton Lane, London SW15 5PN

Tel 0208 487 6087/6092

**ROEHAMPTON SPECIAL SEATING – INITIAL REFERRAL FORM**

IF YOUR CLIENT IS NEW TO THE SPECIAL SEATING SERVICE OR HAS NOT BEEN SEEN FOR TWO YEARS PLEASE USE THIS FORM.  OTHERWISE PLEASE COMPLETE THE REVIEW REFERRAL FORM.

THIS FORM SHOULD BE COMPLETED BY THE CLIENT’S OCCUPATIONAL THERAPIST OR PHYSIOTHERAPIST OR OTHER RELEVANT PROFESSIONAL WITH THE ASSISTANCE OF THE CLIENT, CARERS AND WHEELCHAIR SERVICE MANAGER

The Special Seating Service cannot be held responsible for any adverse incidents that occur due to omissions or inaccuracies in the information provided on this referral form.

**NB. Please respond to all questions even if not applicable, to indicate that you have considered the question and not overlooked it.**

|  |  |
| --- | --- |
| Preferred clinic site |  |

**SECTION 1: GENERAL INFORMATION AND CLINICAL DETAILS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Surname: |  | DOB: |  | Gender: | M | F |
| First name: |  | NHS number: |  | | | |
| Address: |  | | | | | |
|  | | | | | | |
|  | | | | | | |
| Post code: |  | Tel No: |  | | | |

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| --- | --- | --- | --- |
| 2) Next of Kin: |  | | |
| Relationship: |  | | |
| Address: |  | | |
|  |  | | |
| Post code: |  | Tel No: |  |

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| --- | --- | --- | --- |
| 3) Name of Treating Physiotherapist: | | 4) Name of Treating Occupational Therapist: | |
|  | |  | |
| Address: |  | Address: |  |
|  | |  | |
|  | |  | |
| Tel No: |  | Tel No: |  |

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| --- |
| 5) Name, address and contact details of other relevant individuals. E.g. Key worker, Orthotist etc: |
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| --- | --- | --- | --- |
| 6)  Does your client or their family have any special requirements that we need to provide for when they attend our clinic e.g. interpreter? | | | |
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| Client’s name: |  | Date of birth: |  |

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| 7)  Primary Diagnosis: |  |
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| 8)  Other medical conditions (if applicable): |  |
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| --- | --- |
| 9)  Client weight: (Kilos): |  |

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| --- | --- | --- | --- | --- |
| 10)  Name and address of GP: | |  | | |
|  | | | | |
|  | | | | |
| Post code |  | Tel No: |  | |
| 11)  Name and contact details of Paediatrician & other Doctors involved: | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
| 12) Relevant clinics attended in the last 18 months e.g. Wheelchair, Neurology, Orthotics etc | | | | |
| a) | | | Date |  |
| b) | | | Date |  |
| Please include copies of reports where possible. | | | | |

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| --- | --- | --- |
| 13)  Does your client have respite care? If Yes please provide address and frequency of use | Yes | No |
|  | | |
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| --- | --- | --- | --- |
| 14)  Does your client take any form of medication? If Yes please state name and dose. | | Yes | No |
| a) | c) | | |
| b) | d) | | |

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| --- | --- | --- |
| 15) Does your client have seizures?  If Yes please give details (e.g. frequency) | Yes | No |
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| 16) Has your client had any X-rays in the last year? If Yes please include report or ensure x-rays are brought to clinic. | | Yes | No |
| Summary of report: | . | | |
|  | | | |
|  | | | |
| NB X-rays may need to be arranged before a final prescription can be made. | | | |

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| --- | --- | --- | --- | --- |
| 17) Has your client been in hospital for surgery? | | | Yes | No |
| If Yes please state procedure and dates | | | | |
| a) | Date: |  | | |
| b) | Date: |  | | |

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| 18) Has your client been admitted to hospital for any other reason in the last 3 years?  If Yes please give details. | | | | Yes | No |
|  | | | | | |
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| Client’s name |  | Date of birth: |  | | |

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| 19) Head control (Please tick) | | | | | | | | | |
| Good |  | | | Fair |  | Poor |  | None |  |
| Comments: | |  | | | | | | | |
| 20) Trunk control (Please tick) | | | | | | | | | |
| Good |  | | | Fair |  | Poor |  | None |  |
| Comments: | |  | | | | | | | |
| 21) Sitting balance (Please tick) | | | | | | | | | |
| Good |  | | | Fair |  | Poor |  | None |  |
| Comments | | |  | | | | | | |

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| --- | --- | --- | --- |
| 22) Please indicate your client’s level of muscle tone (Please select) | | | |
|  | High Tone | Normal | Low Tone |
| Lower Limbs |  |  |  |
| Upper Limbs |  |  |  |
| Trunk |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| 23) Please indicate your client’s level of deformity  (Please select) | | | | | | |
|  | Ankles | Knees | Hips | Spine | Shoulders | Other (Please state) |
| Dislocations |  |  |  |  |  |  |
| Contractures |  |  |  |  |  |  |

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| --- | --- | --- |
| 24) Do you feel your client’s postural condition is changing? If Yes please give details. | Yes | No |
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| 25) Does your client have physiotherapy? If Yes please give details | Yes | No |
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| 26) Has your client ever suffered from tissue breakdown? If Yes please give details. | Yes | No |
|  | | |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 27) Please describe your client’s level of comprehension: | | | | | | |  | | | | | | |
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| 28) Please describe how your client communicates: | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| 29) Does your client have impaired vision? | | | | | | | | | | | Yes | No | |
|  | | | | | | | | | | | | | |
| 30) Does your client have impaired hearing? | | | | | | | | | | | Yes | No | |
|  | | | | | | | | | | | | | |
| 31) Please describe your client’s functional ability: | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| 32)  Eating (Please tick) | | | | | | | | | | | | | |
| Independent |  | Assisted |  | Dependant |  | | | NG Tube |  | Gastrostomy | | |  | |
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| --- | --- | --- | --- |
| Client’s name |  | Date of birth: |  |

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| 33) Please describe your client’s level of dependency: |  |
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|  | |
| 34) How does your client manage his / her bowels & bladder | |
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**SECTION 2: ABOUT YOUR CLIENT’S POSTURAL & MOBILITY EQUIPMENT.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1) Does your client use static seating? If Yes please state type. | | | | Yes | | No |
| Home: |  | School/Day Centre: |  | | | |
| 2) Does your client use a standing frame? . | | | | Yes | | No |
|  | | | | | | |
| 3) Does your client use any night time support? | | | | Yes | | No |
|  | | | | | | |
| 4) Does your client use any orthotic appliances? E.g. spinal brace, foot splints etc. If Yes please state type and ensure these are brought to clinic. | | | | | Yes | No |
| a) | | | | | | |
| b) | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 5) Does your client currently use special seating in a wheelchair or buggy? | | | | | | | | | | | | | | | | | | | | | Yes | | No | |
| If Yes state type of special seating | | | | | | | | |  | | | | | | | | | | | | | | | |
| Where issued: | | |  | | | | | | | | | | | Date of issue: | | | | | | |  | | | |
| Please state make of wheelbase (manual) | | | | | | | | | | |  | | | | | | | | | | | | | |
| Size |  | | | | | | | Date of issue: | | | | | | |  | | | | | | | | | |
| 6) If applicable what is your client’s ability to self-propel? (Please tick) | | | | | | | | | | | | | | | | | | | | | | | | |
| Good | | |  | | Average | |  | | | | | Poor | | |  | | Fluctuates | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| 7)  Does your client use a special cushion? If Yes please state type. | | | | | | | | | | | | | | | | | | | | | Yes | | No |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| 8) Please state current type of wheelchair (power) and state if it is indoor or indoor / outdoor | | | | | | | | | | | | | | | | | | | | | | | |
| Make | |  | | | | | | | | Size | | |  | | | Date of issue | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| 9) If applicable please state type of controller and how it is used: (Please tick) | | | | | | | | | | | | | | | | | | | | | | | |
| Right handed | | | |  | | Left handed | | | |  | | | Head | | |  | | Tray mounted | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| 10) If applicable what is your client’s ability to control a powered wheelchair? (Please tick) | | | | | | | | | | | | | | | | | | | | | | | |
| Good | | | |  | | Average | | | |  | | | Poor | | |  | | Fluctuates | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| 11) Has your client passed a power chair proficiency test? | | | | | | | | | | | | | | | | | | | | | Yes | | No |
|  | | | | | | | | | | | | | | | | | | | | | | | |

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| 12) Have you assessed your client in any other type of special seating? If Yes  please give details. | Yes | No |
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| --- | --- | --- | --- | --- | --- | --- |
| 13) Does your client use a communication aid? If Yes please state type. | | | | | Yes | No |
|  | | | | | | |
| How is it fitted? |  | | Who was it fitted by? |  | | |
| Is it compatible with the wheelchair? | |  | | | | |
|  | | | | | | |

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| --- | --- | --- | --- |
| Client’s name |  | Date of birth: |  |

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| --- | --- | --- |
| 14) Is your client dependent on an oxygen cylinder? | Yes | No |
|  | | |
| 15) Is any other equipment carried on the wheelchair? If Yes please give details | Yes | No |
|  | | |

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| --- | --- | --- | --- |
| 16) How long does your client currently spend in his or her special seating system / wheelchair? | | | |
| ?/24 hours |  | ?/7 days |  |

**SECTION 3 - ENVIRONMENTAL & TRANSPORTATION RISKS**

**The following details will form part of the Roehampton Special Seating Team Risk Assessment and will be referred to should an incident arise.**

**Where possible all clients should be transferred to an approved safety seat.  If this is not possible the client’s wheelchair should be secured using approved 4 point webbing restraints and the client should be secured with a 3 point lap and diagonal split reel belt, preferably top mounted. These restraints should meet ISO 10542-1. The manufacturer’s instructions should be followed at all times.  All loose pieces of equipment should be stowed safely.  Headrests should be used and clients must always travel forward facing and trays should always be removed.**

**It is the duty of those responsible for providing transport for the client to carry out a full client specific Risk Assessment to minimize the risks of travelling and to establish whether this client can be transported safely. The client’s opinions and the risks and benefits of transportation should be taken into account when carrying out this process. This process should be carried out with input from the client, the client’s parents /carers, the client’s therapists and the Wheelchair Service.**

**The Special Seating service cannot be held responsible for any risks that your client is exposed to as a result of errors or omissions in the information that has been provided.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1) Does your client intend to travel in his/her wheelchair in transport? | | | | | Yes | No |
| If Yes please complete 1a) – g). If No please go to Question 2. | | | | | | |
| a)Please state type of vehicle: e.g. school bus, ambulance, taxi, MPV etc. | | | | | | |
|  | | | | | | |
| b) How will your client be secured? | |  | | | | |
|  | | | | | | |
| c) How will the wheelchair be secured? | |  | | | | |
|  | | | | | | |
| d) How will loose equipment be stowed safely? | |  | | | | |
|  | | | | | | |
| e) How will your client enter/ exit the vehicle? E.g. ramp, tail lift etc. If applicable please give  angle of ramp (e.g. 12°) | | | | | | |
|  | | | | | | |
| f) Please give minimum clearance height for entry, exit and travelling in vehicle (in mm.). | | | | | | |
|  | | | | | | |
| g) If applicable please give space within your vehicle for wheelchair restraint. | | | | | | |
| Width (mm) |  | | Length (mm) |  | | |
|  | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 2) Does the equipment need to be stowed in the boot of the vehicle? If Yes  please go to section 4. | | | | Yes | No |
|  | | | | | |
| Client’s name |  | Date of birth: |  | | |

|  |  |  |
| --- | --- | --- |
| 3) Has a risk assessment been carried out to minimise the risks associated  with travelling in transport? | Yes | No |
|  | | |
|  | | |

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| --- |
| 4) Please state who is responsible for ensuring that your client is travelling as safely as  possible when using transport & whether this person has undergone training. |
|  |
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| --- | --- | --- | --- |
| 5) Does any equipment travel with the client on the wheelchair? | | Yes | No |
| a) If Yes, were the risks assessed? | | Yes | No |
|  | | | |
|  | | | |
| b) If Yes, how is the equipment secured? |  | | |
|  | | | |
|  | | | |

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| --- | --- | --- |
| 6) Has your client ever been involved in a transport related incident? If Yes  please give details | Yes | No |
|  | | |
|  | | |

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| --- | --- | --- |
| 7) Do you feel there are any particular risks to your client whilst being transported  in his/her wheelchair? If Yes please give details: | Yes | No |
|  | | |
|  | | |

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| --- |
| 8) Please give full names, addresses & designations of persons who we should send  transportation  details to for any new seating system prescribed |
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| --- |
| 9) Please give the name & address of the organisation responsible for transporting your client. |
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**N.B If the above information is not provided an extra set of transportation details will be sent to the Wheelchair Service Manager and it will become their responsibility to distribute these details.**

**SECTION 4: OTHER ENVIRONMENTAL ISSUES**

**It is the duty of the Wheelchair Service to assess the risks associated with wheelchair use for this client. In order that these risks are minimised these risks must be identified & addressed.**

**The following section is designed to identify the risks so that they can be taken into consideration by the Special Seating Service.**

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| --- | --- | --- | --- |
| Client’s name |  | Date of birth: |  |

|  |  |  |
| --- | --- | --- |
| 1) Has a risk assessment been carried out to identify and minimise the risks associated with your client using his/her special seating system and wheelchair? If Yes please enclose a copy | Yes | No |
|  | | |

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| --- | --- | --- |
| 2) Do you feel there are any particular risks to your client in his/her environment? If Yes please provide details. | Yes | No |
|  | | |
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| --- | --- | --- | --- |
| 3) Please give details of the environment where the wheelchair is to be used.  Please give angles if greater than 10º | | | |
|  | Home and Work | School or College | Other Environments |
| Ramps |  |  |  |
| Slopes |  |  |  |
| Steps |  |  |  |
| Uneven Ground |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 4) Is the equipment to be used in a wheelchair-adapted environment? | | | | Yes | No |
|  | | | | | |
| 5) If space is an issue in any environment, please give details of maximum width and length of wheelchair.  Take into consideration door widths, turning circles and lift width and length | | | | | |
| Width: (mm) |  | Length: (mm) |  | | |
| 6) Please give maximum floor to canvas height if relevant. (mm) | | |  | | |
| 7) Please give maximum table or desk height if relevant:   (mm) | | |  | | |
|  | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 8) Please indicate how your client transfers into and out of his/her wheelchair: (Please tick) | | | | | | | | | |
| Hoist |  | Manual lift |  | Standing transfer |  | Sliding board |  | Other (Please state) |  |
|  | | | | | | | | | |

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| --- | --- | --- |
| 9) Does your client rock his/her wheelchair in such a way that may pose a risk to stability? | Yes | No |
|  | | |
| 10) Are there any other risks to wheelchair stability that should be taken into  consideration? E.g. Equipment fastened to wheelchair, other clients/children etc tipping wheelchair over. If Yes please give details. | Yes | No |
|  | | |
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| --- | --- | --- |
| 11) Has your client ever been in an accident related to the wheelchair? If Yes please  give details. | Yes | No |
|  | | |
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| --- |
| 12) Who will be responsible on a day-to-day basis for the continued safety of the client and  suitability of the equipment once issued? |
|  |
|  |
| 13) Who will be responsible for informing the Roehampton Special Seating Team should a potential risk to your client’s safety or health arise? (in relation to the wheelchair and/or seating system) |
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| --- | --- | --- | --- |
| Client’s name |  | Date of birth: |  |

**SECTION 5: REASON FOR REFERRAL**

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| 1) Please describe your client’s seating problem: |  |
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| --- |
| 2) What are your aims and objectives with regards to the potential provision of special seating |
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| --- | --- | --- | --- | --- | --- |
| 3) Please prioritise the following.  1 being most important 7 being least important: | | | | | |
| Comfort |  | Mobility |  | Postural Control |  |
| Aesthetics |  | Maximise functional ability |  | Tissue Viability |  |
| Other (Please State) | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **To enable the seating team to gather the information to prescribe the most suitable piece of equipment, and in order that the equipment is used effectively & safely, it is essential that the client attends the clinic with his or her treating therapist and/or other relevant professionals.  The client may need a further 3 follow-up appointments before the seating system is delivered.**  **Please give the name and designation of the professional that will be attending with the client. This professional will be expected to take responsibility for passing on relevant safety guidance issued at delivery & to sign to confirm that the risks involved in using this equipment have been considered & minimised as far as possible.**  **Any equipment manufactured & issued by the Special Seating Service will be either a Custom Made or CE marked Class One Medical Device therefore the initial handover can only be made to a relevant professional.** | | | |
| Name |  | Designation |  |

**Please provide the name and address of whom you would like appointment letters sent, unless noted elsewhere on the referral form.**

|  |  |  |
| --- | --- | --- |
| Appointment letters to be sent to: |  |  |
|  |  |  |

**Appointments will not be made until the section below has been signed by both the referring therapist and the wheelchair service manager.**

|  |  |  |  |
| --- | --- | --- | --- |
| Signature. (Referring therapist) |  | Date: |  |
| Signature (Wheelchair Service Manager) |  | Date |  |

|  |  |
| --- | --- |
| Funding District Wheelchair Service |  |