

Special Seating Service

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ROEHAMPTON SPECIAL SEATING – REVIEW REFERRAL FORM

IF YOUR CLIENT IS KNOWN TO THE SPECIAL SEATING SERVICE AND HAS BEEN SEEN IN THE LAST TWO YEARS PLEASE USE THIS FORM. OTHERWISE PLEASE COMPLETE THE INITIAL 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	
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SECTION 1: GENERAL INFORMATION AND CLINICAL DETAILS

1) Surname:		DOB:		Gender:	M	F
First name:		NHS number:				
Address:						
Postcode:		Tel No:				

2) Next of Kin:						
Relationship:						
Address:						
Postcode:		Tel No:				

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

5) Name, address and contact details of school/Day Centre?
6) Name, address and contact details of other relevant individuals. E.g. Key worker, Orthotist etc:

Client's name:		Date of birth:	
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7) Does your client or their family have any special requirements that we need to provide for when they attend our clinic e.g. interpreter?

8) Client weight: (Kilos):	
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9) Name and address of GP:			
Postcode		Tel No:	

10) Name and contact details of Paediatrician & other Doctors involved:

11) 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.		

12) Does your client have respite care? If Yes please provide address and frequency of use.	Yes	No

13) Does your client take any form of medication? If Yes please state name and dose	Yes	No
a)	c)	
b)	d)	

14) 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.		

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

16) Has your client been admitted to hospital for any other reason in the last 3 years? If Yes please give details.	Yes	No

17) Do you feel your client's postural condition is changing? If Yes please give details.	Yes	No

18) Has your client ever suffered from tissue breakdown? If Yes please give details.	Yes	No

Client's name		Date of birth:	
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19) Does your client have physiotherapy? If Yes please give details	Yes	No

SECTION 2: ABOUT YOUR CLIENT'S CURRENT POSTURAL AND MOBILITY EQUIPMENT.

1) Does your client use any orthotic appliances? E.g. spinal brace / foot splints. If Yes please state type and ensure these are brought to clinic.	Yes	No
a)		
b)		

2) Does your client currently use special seating in a wheelchair or buggy other than that issued by Roehampton Special Seating Service?	Yes	No
If Yes state type of special seating		
Where issued:		Date of issue:
Please state make of manual wheelbase :		
Size		Date of issue:
3) If applicable what is your client's ability to self-propel? (Please tick)		
Good	Average	Poor
		Fluctuates

4) Does your client use a powered chair other than that issued by Special Seating? If Yes please complete question 4a) – c). If No please go to Question 5,			
a) Make	Size	Date of issue	
b) Please state type of controller and how it is used: (Please tick)			
Right handed	Left handed	Head	Tray mounted
c) What is your client's ability to control a powered wheelchair? (Please tick)			
Good	Average	Poor	Fluctuates
d) Has your client passed a power chair proficiency test?			
	Yes	No	

5) 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?		

6) Is your client dependent on an oxygen cylinder?	Yes	No
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7) Is any other equipment carried on the wheelchair? If Yes please give details	Yes	No
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8) How long does your client currently spend in his / her special seating system / wheelchair?		
?/24 hours		?/7 days

Client's name		Date of birth:	
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SECTION 3 - ENVIRONMENTAL AND 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? If Yes please answer questions 1a) – g). If No please go to Question 2	Yes	No
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 and exit the vehicle? E.g. ramp, tail lift etc. If applicable please give angle of ramp (e.g. 12°)		
f) Please give minimum height clearance 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
3) Has a risk assessment been carried out to minimise the risks associated with travelling in transport?	Yes	No
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.		
Client's name		Date of birth:

5) Does any equipment travel with the client on the wheelchair?	Yes	No
a) If Yes were the risks assessed?		
b) If Yes, how is the equipment secured?		

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

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

8) Please give full names, addresses & designations of persons who we should send transportation details to for any new seating system prescribed

9) Please give the name & address of the organisation responsible for transporting your client.

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.

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

2) Do you feel there are any particular risks to your client in his/her environment? If Yes please provide details.	Yes	No
Client name:		Date of birth:

3) Please give details of the environment where the wheelchair is to be used. Please give angles if greater than 10°

	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)	

9) Does your client rock his/her wheelchair in such a way that may pose a risk stability?	Yes	No
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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 when 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)	
Client's name	Date of birth:

SECTION 5: REASON FOR REFERRAL

1) Please describe your client's seating problem:

2) What are your aims and objectives with regards to the potential provision of special seating

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	
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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:		

N.B 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	
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