PLEASE COMPLETE ALL SECTIONS, OTHERWISE FORM WILL BE RETURNED

Acceptable file formats are PDF or DOC

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| --- | --- |
| Client details NHS number: Click here to enter text. | DOB Click here to enter a date. |
| Surname: Click here to enter text. | Title: Choose an item. |
| Forename: Click here to enter text. | Male [ ]  Female [ ]  |
| Address: Click here to enter text. |
| Click here to enter text. | Postcode: Click here to enter text. |
| Tel no: Click here to enter text. | Mobile: Click here to enter text. |
| Ethnicity: Click here to enter text. | Interpreter required? Y [ ]  N [ ]  |
| NOK/other contact Click here to enter text. |
| NOK tel no: Click here to enter text. |
| Other details eg should visit in pairs, key safe number:  |
| Click here to enter text. |

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| Diagnosis & PMH (wheelchairs are only provided to those with permanent disability)Click here to enter text. |
| Height: Click here to enter text. | Weight: Click here to enter text. kg  |
| Current medical status Stable [ ]  Deteriorating [ ]  Improving [ ] Use of arms (e.g. strength to self-propel) Click here to enter text.Use of legs (e.g. contractures, ability to walk) Click here to enter text. |
| **Reason for referral** Click here to enter text. |
| New wheelchair user [ ]  | Current wheelchair user [ ]  |
| **Expected use of wheelchair** Full time ie cannot walk [ ]  Part time [ ]  |
| **Type of wheelchair** Transit ie pushed by carer [ ]  |
|  Self-propelling [ ]  |
|  Powered wheelchair [ ] *NB powered wheelchairs for outdoor use only are NOT supplied by the NHS – please direct client to private funding for these*. |

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| **Referrer Details** |
| GP Name Click here to enter text. Practice Code Click here to enter text. |
| Practice name & Address Click here to enter text. |
|  Click here to enter text. | Tel no: Click here to enter text. |
| CCG Choose an item. |
| Signature | Date Click here to enter a date. |

Email (from NHS.net only) Stgh-tr.roehamptonwheelchairservice@nhs.net