PLEASE COMPLETE ALL SECTIONS, OTHERWISE FORM WILL BE RETURNED

Acceptable file formats are PDF or DOC

|  |  |
| --- | --- |
| 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, safe guarding concerns:  |
| Click here to enter text. |

|  |
| --- |
| Diagnosis & relevant past medical history. Only provide a brief history that is relevant to their mobility and postureClick 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** (wheelchairs are only provided to those with permanent disability)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 Please complete page 2 |

**Type of Property** Ground floorFlat [ ]  Flat with stairs [ ]

Flat with lift [ ]  House [ ]  Bungalow [ ]

Is client appropriate for a video assessment? Yes [ ]  No [ ]

The client is aware this referral is being made? Yes [ ]  No [ ]

Powered Wheelchair

*NB powered wheelchairs for outdoor use only are NOT supplied by the NHS – please direct client to private funding for these*.

Is client able to walk indoors Yes [ ]  No [ ]

Is client able to self-propel a manual wheelchair indoors Yes [ ]  No [ ]

Is patient affected by epilepsy or blackouts Yes [ ]  No [ ]

If so, has the client had a seizure, blackout, etc in the past year? Yes [ ]  No [ ]

Has the client been prescribed any medication that Yes [ ]  No [ ]

affects their ability to drive?

Is the patient visually impaired? Yes [ ]  No [ ]

Does the patient have any mental health problems that would Yes [ ]  No [ ]

affect their ability to safely operate a powered wheelchair?

Do you have any other reason to believe that the patient is Yes [ ]  No [ ]

not medically fit to drive a powered wheelchair

Comment:

|  |
| --- |
| **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) wheelchairservicereferrals@stgeorges.nhs.uk