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 posture  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** (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](mailto:wheelchairservicereferrals@stgeorges.nhs.uk)