## Wheelchair Service Ref No:

# 

## CONFIDENTIAL

### WHEELCHAIR REFERRAL

Referrals are accepted from Occupational Therapists, Physiotherapists, or Clinical Nurse Specialists.

**Wheelchairs to meet short term needs should be requested from British Red Cross or similar agencies.**

|  |  |  |  |
| --- | --- | --- | --- |
| First name of client: Click here to enter text. | | Surname of client: Click here to enter text. | |
| Title Choose an item. | Date of Birth:Click here to enter a date. | | NHS number: 0 |
| Address: Click here to enter text.  Postcode: Click here to enter text. | | | Telephone Click here to enter text.  Landline: Click here to enter text.  Mobile: Click here to enter text. |
| Client email address: Click here to enter text. | | | |

|  |  |
| --- | --- |
| Client height: Click here to enter text. | Client weight: Click here to enter text. kg |

|  |  |
| --- | --- |
| Name of Carer/Contact: Click here to enter text. | Status: Click here to enter text. |
| Telephone: Click here to enter text. |  |
| Delivery Address (if different from above)  Name: Click here to enter text.  Address: Click here to enter text. | |
| Telephone: Click here to enter text. | |

|  |  |
| --- | --- |
| DIAGNOSIS & OTHER RELEVANT INFORMATION *(eg prognosis, PMH, GMFCS level)*  Click here to enter text. | |
| If in-patient, discharge destination: Click here to enter text. | Proposed discharge date: Click here to enter a date. |

|  |  |
| --- | --- |
| GP Practice Code: Click here to enter text. CCG: Choose an item.  GP Practice Name Click here to enter text.  Address (including postcode) Click here to enter text. | |
| Referrer’s details:  Name: Click here to enter text.  Address: Click here to enter text.  Postcode: Click here to enter text. | Profession: Choose an item.  Signature (unless electronically sent)  Date Click here to enter a date. |
| Email address Click here to enter text. | Tel no: Click here to enter text. |

|  |  |
| --- | --- |
| Client Name | Click here to enter text. |

**\*Please be aware that we usually visit clients on our own so if there are any issues with visiting that you wish us to be aware of, please tick and we will contact you before arranging an appointment.**

|  |
| --- |
| Balance *(sitting/standing/static/dynamic):*  Click here to enter text. |
| How does client transfer *(assistance needed, aids used, if any)*?  Click here to enter text. |
| Please describe client’s ability to walk/weight bear and aids used, if any:  Click here to enter text. |
| Ability to self-propel *(are there any contraindications to self-propelling)*?  Click here to enter text. |
| No of hours client likely to spend in wheelchair each day:  Click here to enter text. |
| Will client spend time in other seating?  Click here to enter text. |
| Environmental Factors: type of accommodation, steps/lift to access, internal steps/stairs:  Click here to enter text. |
| Social Situation *(eg family, formal/informal carers, day centre, school, challenging behaviour)*  Click here to enter text. |

|  |  |
| --- | --- |
| **TRANSPORT** | Client will travel in wheelchair in an adapted vehicle Choose an item. Wheelchair will be carried in a vehicle boot |

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| Name & Address of transport provider  Click here to enter text. |

|  |  |
| --- | --- |
| Client Name | Click here to enter text. |

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| **FURTHER INFORMATION TO SUPPORT REQUEST** *(interpreter required, can client answer door?)*  Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| CLIENT ALREADY HAS A WHEELCHAIR | YES | NO |
| Anticipated use of Wheelchair | Full time | Occasionally |
| How many times a week\_\_\_\_\_\_ | Indoors | Outdoors |

WHEELCHAIR DETAILS

**Please fill in client measurements, tick the type of wheelchair and seat size required or complete section 4 for further assessment**.

|  |
| --- |
| **ACTUAL USER MEASUREMENTS (Seated - keeping tape measure straight)**  a) Hip width: \_\_\_\_Click here to enter text.\_\_\_\_  b) Back of buttocks to back of knee \_\_Click here to enter text.\_\_\_\_  c) Back of knee to heel \_\_Click here to enter text.\_\_\_\_\_\_ |

1. **TRANSIT WHEELCHAIR TO BE PUSHED BY CARER : select size below**

(Small back wheels, detachable arms, folding back)

1. **SELF PROPELLING WHEELCHAIR : select size below**

Large back wheels with hand rims, detachable arms, folding back)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 38 x 40cm  (15” x 16”) | 40 x 40cm  (16” x16”) | 43 x 43cm  (17”x17”) | 45 x 43cm  (18”x17”) | 48x43mm  (19x17”) | Other (please specify) Click here to enter text. |

If for use indoors, have you confirmed size selected will fit round home environment? Choose an item.

Comments …Click here to enter text.………………………………………………………………………………………………..

**3**. **MACLAREN’S** **CHILDREN’S BUGGY –** Folding with detachable footboard

|  |  |
| --- | --- |
| Client Name | Click here to enter text. |

|  |
| --- |
| **4. ASSESSMENT BY WHEELCHAIR SERVICE THERAPIST** *(specify aims of assessment)*  (NB powered wheelchairs for outdoor use only are not available from the NHS)  Click here to enter text. |

**ACCESSORIES: Please tick as required.**

Elevating legrest Right  Left

Stumpboard Right  Left  Will footplates also be required? Choose an item. Anti tippers

Cushion (provided for full time users only):

please indicate level of pressure relief required …Click here to enter text.………………………………………………………..

Other *(please specify)* …Click here to enter text.………………………………………………

**ETHNIC CODE: please select**

|  |  |  |  |
| --- | --- | --- | --- |
| WHITE | | BLACK OR BLACK BRITISH | |
| A | BRITISH | M | CARIBBEAN |
| B | IRISH | N | AFRICAN |
| C | ANY OTHER WHITE BACKGROUND | P | ANY OTHER BLACK BACKGROUND |
| MIXED | | OTHER ETHNIC GROUPS | |
| D | WHITE & BLACK CARIBBEAN | R | CHINESE |
| E | WHITE & BLACK AFRICAN | S | ANY OTHER ETHNIC GROUPS |
| F | WHITE & ASIAN | Z | NOT STATED |
| G | ANY OTHER MIXED BACKGROUND |  |  |
| ASIAN OR ASIAN BRITISH | |  | |
| H | INDIAN | J | BANGLADESHI |
| I | PAKISTANI | K | ANY OTHER ASIAN BACKGROUND |

|  |  |
| --- | --- |
| Client Name | Click here to enter text. |

**TO PROCESS THIS PRESCRIPTION, THE REFERRING THERAPIST MUST TICK BELOW TO CONFIRM THE FOLLOWING:**

This application has been made with the client’s agreement

I will instruct the client/carer how to use the type of equipment prescribed

I will inform the client’s GP of this referral

I will instruct the client to read the Conditions of Loan and handbook provided with the chair

I will demonstrate the safe and correct use of the equipment to the client and carer, and

ensure the chair has been adjusted to suit the client’s needs

I have advised the client & carer to contact the Wheelchair Service Approved Repairer

If repairs are needed

I have advised the client to contact the Wheelchair Service if they have any queries or

concerns or require assessment in the future

I have given the client the Wheelchair Service telephone number

Return this form by email to

## 

[wheelchairservicereferrals@stgeorges.nhs.uk](mailto:wheelchairservicereferrals@stgeorges.nhs.uk)

Acceptable file formats are JPG, PDF or GIFF

**It is the referrer’s responsibility to ensure that confidential information is sent securely.**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED OR THE FORM WILL BE RETURNED**