

East Berkshire Specialist Wheelchair Service

3 Abell Gardens

Maidenhead

Berkshire

SL6 6PS

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WHEELCHAIR REFERRAL FORM

Date received:

Ref No:

All applicants must meet the following eligibility criteria(available on request). All provision is for:

- **INDOOR** use. Outdoor only wheelchairs will **NOT** be provided.
- Individuals who have a clinical need for **≥ 6 months** or who are **end of life**.
- **MOBILITY, NOT** on social, transport or educational grounds.

Please complete all sections possible and forward the form to address above. Starred fields (*) must be filled in, or the form cannot be processed and will be returned.

ALERT NOTIFICATION (e.g. Visit in pairs, Safeguarding concerns, communication issues):

PATIENT IDENTIFICATION:		REFERRER IDENTIFICATION										
*Full name:		*Full name:										
*Title:	*Gender:											
*Address:		*Address:										
*Postcode:		*Postcode:										
*Home Telephone No: *Mobile No: Email address:		*Telephone No: Email address: Alternative/monitored email address (required):										
*Ethnicity: *Date of Birth: *NHS No: <table border="1" style="width: 100%;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>											*Designation of referrer (e.g. GP, DN, Therapist)	*Signature of referrer:
		*Date:										
		*GP Name: *Practice Address:										
		*Telephone No:										
<p>*Is wheelchair required for Hospital Discharge? Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]</p> <p>If yes, please provide the estimated discharge date (EDD).....</p> <p>Please note provision is not guaranteed by the discharge date.</p>												
<p>*Type of wheelchair requested:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  Self-propelled [<input type="checkbox"/>] OR </div> <div style="text-align: center;">  Attendant pushed [<input type="checkbox"/>] OR </div> <div style="text-align: center;">  Powered [<input type="checkbox"/>] </div> </div>												
<p>*Reason for referral e.g. mobility issues, pressure ulcers, review of existing NHS wheelchair or accessories etc:</p> 												
<p>*CHC funded? Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]</p> <p>*If yes name of funding CCG:</p>		<p>*Is the patient a war-pensioner whose mobility has been compromised by active duty? Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]</p>										

MEDICAL HISTORY AND FUNCTION

***Diagnosis and details of medical history** past and present: Please include medical information relevant to the selection of a wheelchair e.g. is self-propelling contra-indicated due to heart, lung conditions etc

***Present Mobility** e.g. use of crutches, sticks, walking frame etc

***What activities does the patient need to do in the wheelchair? (please mark all that apply)**

Mobility within the home Work Education Day Centre Outdoor leisure

Other (please specify):

***How long will the patient be sat in the wheelchair during one day?** hours

*Does the patient already have a wheelchair? If yes, from where? *Previous NHS supply <input type="checkbox"/> NRS <input type="checkbox"/> Red Cross <input type="checkbox"/> Private <input type="checkbox"/> Unknown <input type="checkbox"/> Type of wheelchair (if known):	Yes	No
* Can patient transfer independently? If no, what assistance/equipment is required?		
* Does the patient have a history of falls? If yes, how many falls in the last year?		
*Does the patient need trunk support when sitting? If yes please specify.		
*Will the patient be transported in a vehicle whilst sat in the wheelchair?		
PRESSURE CARE:		
*Does the patient have any history of pressure problems (e.g. marking of the skin/sores)? *If yes please give details, location, grade etc. of historic and current pressure sores.	Yes	No
*Is the patient currently using a pressure cushion? If yes, what type and size (if known)		
Waterlow score (if known) Purpose T score (if known)	or	Braden score (if known) or

NHS No									
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SOCIAL HISTORY

*Type of accommodation (please underline)
 House / Bungalow / Flat / Sheltered Accommodation / Residential Home / Nursing Home / Other (please specify)

Please comment on any aspects of the home environment that need to be considered (e.g. external steps to access house / minimum door width). If a home visit has been completed, please enclose a report:

*Does the patient live alone? Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]	*Does the patient have a regular carer? Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]
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Name of next of kin and relationship to patient:	Next of kin telephone number:
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Name of carer/care agency:	
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Carer's address if different to patient:	Carer's telephone number:
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*Are there any factors about the carer which need to be considered e.g. is the carer elderly, frail, unfit?

*Best contact point for patient:	Delivery address if different:
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ANY ADDITIONAL INFORMATION:

Please include any known names and contact details for other professionals involved:
 e.g. Consultant, Physiotherapist, Occupational Therapist, Community Psychiatric Nurse, District Nurse and any other relevant information that is not recorded on this form. Thank you.

Name of School/Day Centre attended (*if applicable*)

Days attended: Telephone No:

Key/Support Worker/Teacher(s)

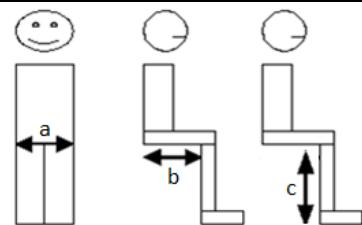
EQUIPMENT REQUIRED**(*THESE MEASUREMENTS ARE ESSENTIAL WHEN REQUESTING CHAIRS FOR HOSPITAL DISCHARGE)**Please provide **UNITS of measure** for the following (e.g. kg, lb, cm, mm, inches)

*Height:

*Weight:

In sitting upright:

a) Hip width - widest part when seated
 b) Thigh length - back to knee crease when seated
 c) Knee crease to heel



For hospital discharge please advise discharge destination:

Is patient under active rehabilitation and likely to improve mobility:

NB: Only a basic manual wheelchair will be supplied for hospital discharge, which can be reviewed post discharge if required.

FOR POWER CHAIR REFERRALS, THE FOLLOWING MUST BE COMPLETED & SIGNED BY THE GP**(NB If referrer is able to obtain the below prior to sending the referral to Wheelchair Service this will speed up the referral process. We cannot proceed with the assessment without this information.)**

Does the patient have:	Yes	No
Epileptic fits? If "yes", are they controlled?		
When was the last one?		
Blackouts or dizzy spells?		
A pacemaker?		
Sufficient vision to be safe when using a powered wheelchair on pavements, crossing roads and in other public places?		
Sufficient general awareness to be safe when using a powered wheelchair on pavements, crossing roads and in other public places?		
Pressure sores? If "yes" state site and grade:		
Is the patient:	Yes	No
Able to walk? If "yes" give details:		
Able to self-propelled a manual chair? If "yes" give details:		
Bowel incontinent?		
Bladder incontinent?		
Is self-propelling a manual wheelchair medically contra-indicated? If "yes" give details:		
Is the provision of an indoor/outdoor electrically powered wheelchair contra-indicated?		
In your opinion are there any other factors that could influence the prescription of an electric wheelchair e.g cognition, environment, substance abuse that could impair ability to use powered chair safely?		
GP Name:	GP signature:	Date: