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| Wheelchair Service Referral Form - Confidential |

INSTRUCTIONS:

* Please ensure the client meet sections a-e in section 1 of the Swindon Wheelchair Service criteria to be considered eligible for provision of equipment, before completing this form.
* This form should be used when a client requires a wheelchair because of a long-term, permanent diagnosed physical condition that restricts their mobility.
* This form should ONLY be completed by the clients GP or another health professional.
* ALL mandatory sections/ information MUST be completed where specified.
* Further information, referral forms and criteria for issue can be found on our website:

<https://www,gwh.nhs.uk/wards-and-services/a-to-z/wheelchair-specialist-seating-service/>

**Incomplete, unsigned and/or undated forms will be returned.**

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| 1. Client Details This section **must** be fully completed
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| **NHS Number:** |  | **Title:** |
|  |  |  |
| **Address:** |  | **Forenames:** |
|  |  |
|  | **Surname:** |
|  |  |
|  | **Date of birth:** |
|  |  |
|  | **Telephone (home):** |
|  |  |
| **Postcode:** |  | **Telephone (mobile):** |
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| **Email address:** |

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| **Client signature:** |

**Has the client consented to this referral? Yes** [ ]  **No** [ ]

**If the client is unable to sign the form, the referrer can write 'Verbal Consent Gained' in the client signature box**

**If someone has consented on their behalf, please provide details below:**

**If the client is a child, who has parental responsibility for them?**

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| **Name:** |  | **Telephone (home):** |
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| **Relationship:** |  | **Telephone (mobile):** |

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| **Name:** |  | **Telephone (home):** |
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| **Relationship:** |  | **Telephone (mobile):** |

**Does the client have any difficulties making their own decisions? Yes** [ ]  **No** [ ]

**Who is the next of kin or person available to consult with regarding this referral ?**

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| **Name:** |  | **Telephone (home):** |
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| **Relationship:** |  | **Telephone (mobile):** |

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| 1. GP details This section **must** be fully completed
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| **GP Practice:** |  | **Name of Dr (if known):** |
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| **Practice Address:** |  | **Telephone:** |
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| **Postcode** |  |  |

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| 1. Referrer details This section **must** be fully completed
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| **Referrer Name:** |  | **Profession:** |
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| **Address:** |  | **Telephone (office):** |
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|  | **Telephone (mobile):** |
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| **Postcode:** |  | **Email address:** |

**Referrers working days: Monday** [ ]  **Tuesday** [ ]  **Wednesday** [ ]  **Thursday** [ ]  **Friday** [ ]

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| 1. Carer Details
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| **Carers Name:** |  | **Relationship to client:** |
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| **Address:** |  | **Telephone (home/office):** |
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|  | **Telephone (mobile):** |
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| **Postcode:** |  | **Email address:** |
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| **Relevant carer needs:** |

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| 1. Medical History Diagnosis **must** be completed
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| **Diagnosis:** |
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| **Allergies:** |

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| **Does the client have any behavioural needs? Yes** [ ]  **No** [ ] **If Yes, please provide details below, including the Behavioural Support Service involved, as behaviours will need to be addressed prior to referral to this service (see SWS Behavioural Guidelines on our website for further information).** |

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| 6. Wheelchair use This section **must** be fully completed  |

**How many days a week will the wheelchair be used? 1** [ ]  **2** [ ]  **3** [ ]  **4** [ ]  **5** [ ]  **6** [ ]  **7** [ ]

**Period of time sat in wheelchair? <2 hours** [ ]  **2-4 hours** [ ]  **over 4 hours** [ ]

**Where will the wheelchair be used? indoors only** [ ]  **indoors & outdoors** [ ]  **outdoors only** [ ]

**Is the client medically fit to self-propel a wheelchair? Yes** [ ]  **No** [ ]  **Short supervised** [ ]

 **distance only**

**Does the client currently use a wheelchair Yes** [ ]  **No**[ ]

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**If yes how often do they use their wheelchair:**

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| 7. Functional ability This section **must** be fully completed |

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| **Transfer method in/out of wheelchair: Independent** [ ]  **Supervised** [ ]  **Assisted** [ ] **Transfer equipment used:** |

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| **What is the client’s ability to walk? Unable to walk** [ ]  **Indoors only** [ ]  **Short distances** [ ]  **indoors/outdoors** **Walking aids/ prosthesis/ orthosis in use:** |
|  |
| **Postural information:****i.e. factors affecting a client’s ability to sit in a standard wheelchair** |

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| 8. Physical measurements in sitting This section **must** be fully completed |

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|  |  |  | **Measurement** | **Units****cm/inch** |
|  | **A - Hip width** |  |  |
|  | **B – Depth/upper leg length****Rear of buttock to back of knee** |  |  |
|  | **C – Lower leg length****Back of knee to bottom of heel** |  |  |

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| **Height (cm):** |  | **Weight (kg):** |

\*Accurate weight information is essential for prescription of a wheelchair with a suitable weight limit

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| 9. Present condition of client’s skin  |

**Does the client currently have any pressure ulcers? Yes** [ ]  **No** [ ]

**If yes please complete the below table:**

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| --- | --- | --- | --- | --- |
| **Location of pressure ulcer** | **Category of pressure ulcer** | **How long has the ulcer been present?** | **Cause****(if known)** | **Current treatment** |
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**Does the client require more than a basic foam cushion for use in their wheelchair? Yes** [ ]  **No** [ ]

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| 10. Wheelchair requirements Option 1,2, or 3 **must** be completed |

**Please select the reason for your referral from the options below:**

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| **1.** | **I have completed the Swindon Wheelchair Service accreditation course and I wish to prescribe a basic self-propel wheelchair for my client.****Please complete the prescription section below.** | [ ]  |
|  |  |  |
| **2.** | **My client requires an assessment by the Swindon Wheelchair Service for a manual wheelchair or buggy.** | [ ]  |
|  |  |  |
| **3.** | **My client requires an assessment by Swindon Wheelchair Service for an Electrically Powered Indoor Outdoor Chair (EPIOC). Please ensure the client meets points 1-10 of the Swindon Wheelchair Service criteria for issue of an EPIOC.**  | [ ]  |

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| **I, the referrer, confirm that the information supplied with this form is correct to the best of my knowledge and that the client this referral concerns is aware of and agrees with the content of this form.** |
| **Signature:** | **Date:** |

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| 11. Wheelchair Prescription – Accredited Therapists Only |

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| **Accreditation number:**  |

**The client will be sent the wheelchair you prescribe. All wheelchairs will be supplied with a standard 3” foam cushion for adults and 2” foam cushion for children.**

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| **Adult self-propel wheelchair** | **Please select the wheelchair seat size you are prescribing below:****16”x17”** [ ] **17”x17”** [ ] **18”x17”** [ ] **19”x17”** [ ]  |