

# POSTURE & MOBILITY SELF-REFERRAL FORM

**CONFIDENTIAL**

## Leicester Posture & Mobility Services

### Instructions:

- Please only complete this form if you are an existing patient. If you are not yet registered with us, please contact your healthcare professional
- Please complete all sections. Failure to do so will result in the referral being rejected and returned for full completion. This will delay the processing of the referral
- Please email the completed form to: **opcare.wheelchairservices@nhs.net**

### 1. Patient details

*Must be fully completed*

Title:		Forename:		Surname:	
Date of birth:		Gender:		NHS number:	
Address:				Post code:	
Home tel:			Mobile:		
Email:					
Interpreter required?	No		Yes, for the following language:		
Height:		Weight:			

### 2. General Practitioner details

*Must be fully completed*

GP name:		GP number:	
Address:			Post code:
Main tel:		Email:	

### 3. Medical details

*Must be fully completed*

Reason for referral:	Please state which wheelchair/equipment you would like us to review and the reasons why. Please provide as much detail as possible in order to avoid any delays to processing your referral.

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### 4. Existing equipment details

*Must be fully completed*

Equipment type (e.g. transit, self-propelled, powered):

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Equipment model (e.g. Action 3, Spectra, Rea Azalea):

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Asset number (this should be located on a sticker on the lower area of the equipment):

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### 5. Consent and authorisation

*Must be fully completed*

Do you consent to us sharing information with other healthcare providers as needed?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
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Would you like to be kept informed via email?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
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Would you like to be kept informed via text messaging ?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
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### 6. Additional information

Please provide any additional information you believe may assist with, or be essential to, this referral.

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Completed by:

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Date:

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