

POWERED WHEELCHAIR REFERRAL FORM

CONFIDENTIAL

Leicester Posture & Mobility Services

Instructions:

- This form should be used when a client requires a wheelchair because of a permanent illness or disability (permanent is defined as 6 months or more)
- **The Posture & Mobility Service does not provide outdoor-only powered chairs, or scooters**
- This form **MUST** be signed by both the patient's GP AND the Allied Healthcare Professional (AHP) making the referral
- Please ensure the patient's GP has completed section 10 (page 6) of this form in full before submission
- Please complete all sections as marked. Failure to do so will result in the referral being rejected and returned for full completion. This will delay the processing of the referral

1. Patient details						<i>Must be fully completed</i>	
Title:		Forename:		Surname:			
Date of birth:		Gender:		NHS number:			
Address:						Post code:	
Home tel:				Mobile:			
Email:							
Interpreter required?	No	<input type="checkbox"/>	Yes, for the following language:				
Any other communication method required? (I.e.: Braille, British Sign Language, etc.)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	If yes, please specify:		

2. General Practitioner details				<i>Must be fully completed</i>			
GP name:				GP number:			
Address:						Post code:	
Main tel:				Email:			

3. Alternative contact details						<i>Must be fully completed</i>	
Name:				Relationship:			
Address: <small>(If different to section 1)</small>						Post code:	
Email:							
Home tel:				Mobile:			
Is the person named in this section the primary contact for this patient?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>			

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4. Delivery address (if different from patient's home address)		<i>Must be fully completed</i>	
Address:		Post code:	

5. Medical details	<i>Must be fully completed</i>
Medical condition:	

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.		

Is this an urgent case relating to a terminal illness? N.B.: Terminal illness provision is categorised as a patient having a prognosis of <6 months.	Yes		No	
N.B.: We reserve the right to reassess the patient's priority.				
Is further assessment required by the wheelchair service?	Yes		No	

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6. Assessment details										Must be fully completed	
Is a standard foam cushion adequate?				Yes		No					
How does the patient mobilise around the home?											
Independently			With assistance			With a stick					
With a walking frame			Not mobile								
How often will the wheelchair be used per week and for how long each time? (Tick boxes below)											
0 - 2 times		3 - 5 times		5 + times							
Is the patient able to operate a standard joystick control?								Yes		No	
How does the patient transfer?											
Do you have a suggested cushion for this patient?								Yes		No	
If yes, please specify:											
Is the patient able to maintain mid-line sitting balance independently?								Yes		No	
Is there a history of pressure sores?				No		Yes, current		Yes, historical			
For current/historic sores, please provide the location and grade:											
What is the patient's Waterlow or Braden score? (Please specify)											
What is the patient's continence status?											
What type of chair does the patient require? <small>Referrals for manual chairs should be completed on the separate manual chair referral form</small>											

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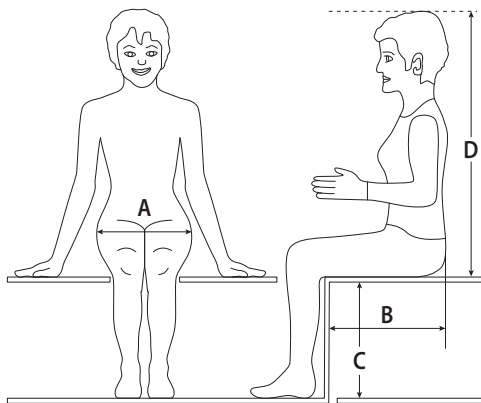
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6. Assessment details Continued from page 3

Taking measurements:

- Please record these measurements with the patient in a sitting position
- Please state the units you have used
- Please measure carefully and do not rely on historic measurements



A – hip width in sitting position	
B – Back of buttocks to back of knee	
C – Back of knee to sole of foot	
D – Seat to top of head	
Height	
Weight	

7. Referrer's details Must be fully completed

Name:		Profession:	
Address:		Post code:	
Email:		Telephone:	
Would you like to be present at any assessment?	Yes	<input type="checkbox"/>	No
<ul style="list-style-type: none"> • Please ensure you read the wheelchair criteria before referring to us, and that you have signed the form as indicated in Section 9 • If providing an email address, please use NHS.net if possible – we will be unable to contact you via unsecure email systems 			

8. Consent and authorisation Must be fully completed

Does the patient agree to be referred to the wheelchair service?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does the patient consent to us sharing information with other healthcare providers as needed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does the patient consent to being kept informed via email?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does the patient consent to being kept informed via text messaging?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Leicester Posture & Mobility Services**9. Additional information**

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

Referrer's signature:

Date:

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10. Information required from patient's GP		<i>Must be fully completed</i>			
Please ask the patient's GP, as named in Section 2, to complete the following short questions. A space is provided below each question for any relevant comments.					
A. Is the patient unable to walk, or self-propel a wheelchair around their home, or do you believe that doing so would put the patient at risk?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comment:					
B. Is the patient affected by epilepsy, or blackouts?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If so, has the patient had a seizure, blackout, etc. in the past year?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comment:					
C. Has the patient been prescribed any medication that affects their ability to drive?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comment:					
D. Can the patient read car number plate 20 meters away?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comment:					
E. Does the patient have any mental health problems that would affect their ability to safely operate a powered wheelchair?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comment:					

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10. Information Required from patient's GP		<i>Continued from page 6</i>	
F. Does the patient suffer from any perceptual deficits, e.g. neglect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Comment:			
G. Are you aware of any other conditions which would affect the patient's safe use of a powered chair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Comment:			
Finally, please sign to confirm that the patient is medically fit to control an electrically powered wheelchair.			
GP's printed name:			
GP's signature:		Date:	