

MANUAL 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)
- This form should ONLY be completed by the patient's GP or Allied Healthcare Professional (AHP)
- Existing patients should contact the wheelchair service directly
- 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
- If you are referring the patient for a powered wheelchair, please use the separate Powered Wheelchair Referral Form in order to expedite the process

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)		Must be fully completed	
Address:		Post code:	

5. Medical details		Must be fully completed	
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 the referral.		
Is this an end-of-life case relating to a prognosis of 6 months or less? N.B.: Provision is categorised as a patient having a prognosis of <6 months.	Yes	<input type="checkbox"/>	No
Is this an urgent case?	Yes	<input type="checkbox"/>	No
Please tell us why it is an urgent case N.B.: We reserve the right to reassess the patient's priority.			
Is this a routine case? N.B.: We reserve the right to reassess the patient's priority.	Yes	<input type="checkbox"/>	No
Is this a hospital discharge patient?	Yes	<input type="checkbox"/>	No
If required for hospital discharge, please state the date required by:			
In addition to any of the above, is a further assessment required by the wheelchair service?	Yes	<input type="checkbox"/>	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								
Where will the wheelchair be used?												
Indoors only			Outdoors only			Indoors and outdoors						
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 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?									Referrals for powered chairs should be completed on the separate powered chair referral form			
 Self-propelling			 Attendant-pushed			 Buggy						
Please state any suggested accessories:												

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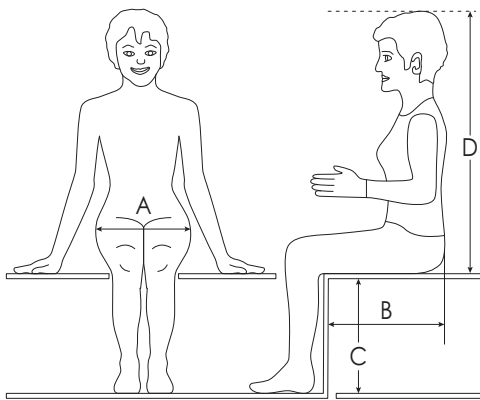
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6. Assessment details

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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	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	No
Does the patient consent to us sharing information with other healthcare providers as needed?	Yes	No
Does the patient consent to being kept informed via email?	Yes	No
Does the patient consent to being kept informed via text messaging?	Yes	No

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9. Additional information

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

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Referrer's signature:		Date:	
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