## WHEELCHAIR AND SPECIAL SEATING SERVICES

Tickhill Road Hospital, Tickhill Road, Balby, Doncaster, DN4 8QN Tel: (01302) 566701 Fax: (01302) 798366



## **REFERRAL FORM**

## PLEASE USE BLOCK CAPITALS THROUGHOUT

This form should be completed and SIGNED by the user's G.P., OCCUPATIONAL THERAPIST, PHYSIOTHERAPIST or OTHER CLINICIANS NOT BY THE CLIENT OR THEIR CARERS

Please Note: Incomplete referral forms will delay provision / assessment and will be returned for full information.

## **ALL ITEMS MARKED WITH \* MUST BE COMPLETED**

USER DETAILS: MALE / FEMALE	FOR OFFICE LISE ONLY					
*SURNAME: MR / MRS / MISS / MS	FOR OFFICE USE ONLY					
*FORENAME:	Date Received					
*ADDRESS:	Ref No.					
	Existing Wheelchair					
POSTCODE:	*Clinic / *Issue (*Delete as appropriate)					
*TEL. NO HOME:	Tast track in priority in startage					
- WORK:	(48 hours) 1-5 days					
DATE OF BIRTH: ETHNICITY:	Endorsed by					
NHS NO: *WEIGHT: ************************************	Date					
*HEIGHTVVEIGHT	Details					
DELIVERY ADDRESS:	For Assessment by:					
	Category of needs:					
NEXT OF KIN / CARER'S NAME:						
ADDRESS:	DATE ACTION					
TELEPHONE AND 10 FD						
TELEPHONE NUMBER:						
*CURRENT MEDICAL HISTORY						
*PAST MEDICAL HISTORY						
Does the client have a history of epilepsy?						
Yes No Date of last seizure						
DO YOU HAVE KNOWLEDGE OF ANY ISSUES WHICH MAY	*NAME OF REFERRER:					
AFFECT STAFF SAFETY?	ADDRESS:					
Yes No						
IF Yes give details	POST CODE:					
	   TELEPHONE NUMBER:					
GP's NAME:	STATUS: DATE OF REQ:					
ADDRESS:	IS THE CLIENT AWARE OF THIS REFERRAL  Y/N					
TELEPHONE NUMBER:	THE CLIENT CONSENTS TO BEING ASSESSED BY A					
GP SIGNATURE:	WHEELCHAIR AND SPECIAL SEATING THERAPIST. Y/N					
GI SIGIVITORE	SIGNED:					
Have you attended Wheelchair Referrers Training?	No Date: Place:					

S THE CHAIR ESSENTIAL FOR HOSPITAL DISCHARGE?		O		
		Yes	☐ No	
PLANNED DISCHARGE DATE:				
S THE PERSON ALREADY IN POSESSION OF A WHEELCHAI	R?	Yes	☐ No	
DETAILS:		☐ NHS	Private	2
S THE CHAIR REQUIRED FOR:	(up to 4 months)	Long Te	rm Loan	
PHYSICAL MEASUREMENTS IN SITTING (This section m	nust be fully completed	d)		
$\circ$		IV	leasurement	Units
	A) * Hip	Width		Inch / cm
A	1 1 1	of buttock ck of knee		Inch / cm
C	,	of knee to of foot		Inch / cm
METHOD OF TRANSFER				
Independent Slide Board	Assistance of	1	Assista	nce of 2
☐ Hoist ☐ Rotunda	Independent	with frame		
ANTIGORATE MAAGE				
ANTICIPATED USAGE  FOR WHAT DURDOSE DOES THIS DERSON REQUIRE TH	IE LISE OE A WHEELCH	IAIR2		
FOR WHAT PURPOSE DOES THIS PERSON REQUIRE TH			n	
FOR WHAT PURPOSE DOES THIS PERSON REQUIRE THE		IAIR? rgy conservation	١	
FOR WHAT PURPOSE DOES THIS PERSON REQUIRE THE Independence with mobility  HOW OFTEN WILL THE CHAIR BE USED?	FatIgue / ene	rgy conservation		
I. FOR WHAT PURPOSE DOES THIS PERSON REQUIRE THE Independence with mobility P. HOW OFTEN WILL THE CHAIR BE USED?  Once a week  2-3 times a week	FatIgue / energy 4-5 times a w	rgy conservation	n   Daily	
I. FOR WHAT PURPOSE DOES THIS PERSON REQUIRE THE Independence with mobility  Property WILL THE CHAIR BE USED?  Once a week  Drope 2-3 times a week  HOW LONG WILL THE PERSON BE SAT IN THE WHEEL	FatIgue / energy 4-5 times a w	rgy conservation		
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I. FOR WHAT PURPOSE DOES THIS PERSON REQUIRE THE Independence with mobility  Property of the Chair Be Used?  Once a week  Once a week  HOW LONG WILL THE PERSON BE SAT IN THE WHEEL  1-2 hours  WHAT WILL THE WHEELCHAIR BE USED FOR?	FatIgue / energy 4-5 times a water CHAIR?  5+ hours	rgy conservation	<b> </b> Daily	and the hom
I. FOR WHAT PURPOSE DOES THIS PERSON REQUIRE THE Independence with mobility  Provided the Person of	FatIgue / energy 4-5 times a w CHAIR? 5+ hours  Shopping	rgy conservation veek		
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I. FOR WHAT PURPOSE DOES THIS PERSON REQUIRE THE Independence with mobility  2. HOW OFTEN WILL THE CHAIR BE USED?  Donce a week  3. HOW LONG WILL THE PERSON BE SAT IN THE WHEEL  1-2 hours  3-4 hours  WHAT WILL THE WHEELCHAIR BE USED FOR?  Social Outings Hospital Visits Work / School / College  PROPOSED USE OF THE WHEELCHAIR  Self propel by client Pushed by  PUSHED BY OTHERS  Who will be pushing the wheelchair?	FatIgue / energy  4-5 times a water  CHAIR?  5+ hours  Shopping Other	rgy conservation veek	Daily Moving arou	
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lame				1	NHS No					
PLEASE SPECIFY THE FC	LLOWING									
WALKING ABILITY:			Unable		Limited Indo	ors		Limit	ed Ou	tdoors
CAN THE USER SIT WITH	THEIR KNEES BENT?	LEF1	T 🔲 Yes		No	RIGHT		Yes		No
DO THEY HAVE DIFFICULT	TY USING THEIR ARMS	? <b>LEF1</b>	Yes		No	RIGHT		Yes		No
SITTING ABILITY:			Normal		Needs Supp	ort				
DO THEY HAVE IMPAIRED	COGNITION?		Yes		No					
If yes, give details:										
IANUAL WHEELCHAIR										
Suggested manual v	VHEELCHAIR / BUGGY	/								
Adult Self Propel	Adult Transit		Paediatric S	elf	Paediatri	c Transi	t		Bugg	
	2 2		Propel		- 5			One	Size	Only
									111	
						2		9		
(金里)	0		342		0				1	b
8	6 -0				9				10	
OWERED WHEELCHAIR	₹									
PLEASI	E NOTE THAT THE N	HS D	O NOT ISSUE	POW	/ERED WHEE	LCHAIR	S SOL	ELY		
	FOR OUTDOOR U	SE. T	HE NHS DOE	S NO	T SUPPLY SC	OOTERS				
CRITERIA FOR POWERI	ED									
Powered indoor whee manual wheelchair.	Ichair: A person must	t requ	ire a wheelch	air for	all mobility a	nd be ur	able t	o self	prope	l a
Powered Indoor / Outo	door Occupant cont	rolled	<b>d</b> ∙ Δs ahove ar	nd the	nerson must	gain inc	reaser	l mohi	lity in	their
local vicinity leading to in			a. As above at	ia trie	person must	gairrine	easec	THOO	iity iii	tileli
Attendant Controlled				be un	able to self p	ropel or	operat	е а ро	owere	d
wheelchair and the main	carer is unable to pu	snar	nanuai Chair.							
TYPE OF POWERED WI	-									
_	led powered indoor									
	led powered indoor									
Attendant contro	lled powered whee	Ichaii	<b>r</b>							
SPECIAL SEATING / PO	STURAL SUPPORT									
Please give details if the	client requires special	seatir	ng.							

Name		
PRESSURE CUSHIONS		
WE DO NOT AUTOMATICALLY GIVE EVERY CLIEN THERE HAS TO BE A MEDICAL NEED FOR THIS I  Clients can purchase a cushion from the wheelch	EQUIPMENT.	
Is the person at risk of pressure sores?	☐ Yes	☐ No
If yes, please indicate level:	pressure sore	At risk
If existing pressure sore: What grade	<b>3</b>	4
Is the person currently using any pressure relieving equipment?  If yes, please state:	Yes	☐ No
Is the person able to relieve pressure?	Partial push	n up 🔲 None
Does the client have continence problems?	Doubly inco	ontinent
The voucher scheme aims to give clients a wider choice of wheelchairs supplied by an NHS wheelchair, the client may contribute to a more expensive wheelchair of the wheelchair and be responsible for its maintenance and	neir choice. The per	
COMMENTS		

Please return completed form to: