Date Received:

Wheelchair Reference Number:

**Worcestershire Wheelchair Service Referral Form**

This form must only be completed by a healthcare professional and only used for people who require a wheelchair indoors for **at least** 6 months. **Incomplete forms will be returned**.

Surname Mr/Mrs/Miss/Ms........................................ Forename................................................

NHS Number............................................................ Date of Birth …...... /……... /……....

Address .......................................................................................................................................... ........................................................................................................................................................

Postcode ................................................. Telephone Number....................................................

Email address ................................................................................................................................

**GP details**

GP Code................................................ CCG................................................................................

GP Name............................................... GP Telephone Number...................................................

GP Address ....................................................................................................................................

**Intended use**

□ All mobility within the home

□ Weekly daycentre or medical appointments

□ Longer outdoor distances (shopping/social use/occasional appointments)

**What type of equipment is requested?**

□ Attendant pushed □ Child’s Buggy □ Postural Support

□ Self propelled □ Indoor powered wheelchair

NB: The NHS does not supply wheelchairs for outdoor only use

**Medical Details**

Height....................................................... Weight ......................................................................

Diagnosis affecting mobility ............................................................................................................

………………………………………………………………………………………………………….......

Describe client’s method of transfer................................................................................................

Describe client’s current level of mobility .......................................................................................

Does the client currently have a wheelchair? □ Yes NHS □ Yes Private □ No

Please detail how the client will get to the appointment

……………………………………………………………………………………………………………..

Please comment on:

|  |
| --- |
| Likely time to be spent in wheelchair:  |
| Continence:  |
| Skin condition: (include information on any pressure ulcers, e.g. site, grade, cause and history)  |
| Postural deformities or contractures:  |

Having completed the referral please choose from the following

□ A further assessment is required

□ The following equipment is appropriate…………………………………………………..

Please use this space for any other information that you feel is relevant to ensure comprehensive assessment and appropriate equipment provision (for example, environmental issues, delivery instructions, social issues, translator required)

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Referrer Signature............................................................................... Date .....................................

Referrer name and profession (block capitals) .................................................................................

Referrer Telephone number..............................................................................................................

Days worked......................................................................................................................................

Wheelchair service to attach

Client sticker here

**Mandatory Data Set**

**Ethnic Origin: Please circle appropriate letter**

**A** British

**B** Irish

**C** Any other white background

**D** White and Black Caribbean

**E** White and Black African

**F** White and Asian

**M** Caribbean

**N** African

**P** Any other black background

**R** Chinese

**S** Any other ethnic category

**Z** Not stated

**G** Any other mixed background

**H** Indian

**J** Pakistani

**K** Bangladeshi

**L** Any other Asian background

**Does the service user/career have a communication/information support need?**

(please choose one or more of the following)

□ No additional communication requirement

□ Braille

□ Large print

□ Easy Read

□ SMS/Text message (mobile number required)

□ Email (address required)

□ Telephone

□ Audio tape/disk

□ British Sign language

□ Lip reading

□ Use of hearing loop

□ Advocacy

□ Interpreter

□ Other – please specify

**Please do not write on this page**