 **Vaughan Building, Ruckhall Lane,**

 **Belmont, Hereford HR2 9RP**

**Tel. 01432 363903**

 **E-mail: wheelchair.service1@nhs.net**

**WHEELCHAIR SERVICE – Referral Form**

**\*\*To be completed by Health/social Care Professional only\*\***

**\*\*NB: Wheelchairs are not provided for outdoor use only unless the client is in end of life stages of a terminal condition\*\***

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| Name: | Title: | Sex: M / F |
| Home Address:Post Code:Telephone No.Any Access issues: | D.O.B.: |
| Ethnic Origin:Religion:NHS No.: |
| Name and Address of G.P |
| Delivery Address/contact details if different from above: |
| Height: | Weight: |

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| Relevant Health Conditions: |

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| **Current level of mobility in the home:** |
| [ ] Walking independently – Describe: |
| [ ] Walking with equipment – Specify:  |
| [ ] Walking with supervision/assistance – Specify:  |
| [ ] Wheeled mobility – Describe:  |
| [ ] Remains in bed |
| [ ] Falls risk |
| **Reason for referral: please select all relevant options** |
| [ ] Fast track manual wheelchair for end of life |
| [ ] Fast track for hospital discharge |
| [ ] Fast track by trusted prescriber: **complete page 3** |
| [ ] Current pressure sore: | Category: | Location: |
| Waterlow: | D/N: |
| [ ] Safety issue – Describe: |
| [ ] WCS Assessment for: | [ ] Manual | [ ] Power | [ ] Posture |
| [ ] Pressure relief | [ ] Other:  |
| Additional information to describe the problems the person is having: |

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| **Able to attend outpatient clinic:**  | [ ] Yes  | [ ] Needs home visit\* – reason: |

(\*NB: Longer waiting times for home visits – please make client aware).

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| **Home environment:** |
| [ ] House | [ ] Bungalow | [ ] Flat | [ ] Other: |
| Access: | Min. door width: |
| Referred for OT assessment [ ] Yes [ ] No |
| **Social circumstances:** |
| [ ] Lives alone | [ ] Lives with: |
| [ ] POC | [ ] Care agency | Frequency: |

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| **Details of referrer:** |
| **Name:**  | **Email:** |
| **Profession:** | **Base & Tel. No:** |
| **Signed:** | **Date:** |

**Page 3 for Trusted Prescribers Only**

**By completing this form you are signing to say you are competent to prescribe a wheelchair from the standard range below and have complied with the service eligibility criteria. Responsibility for this equipment provision will remain with you as the prescriber. Unqualified staff may complete the form on your behalf but the trusted prescriber must countersign.**

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| **Select size of chair from the range below:** |
| [ ] 15 x 16 | [ ] 16 x 16 | [ ] 17 x 17 | [ ] 18 x 17 |
| [ ] Standard seat height – 19” |
| [ ] Low seat to ground height\*: specify height including 2” cushion: |

(\*NB: special order 4-6 weeks)

|  |  |  |
| --- | --- | --- |
| [ ] Attendant propelled | [ ] Self-propelled | [ ] Either |

|  |
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| **Select cushion from the range below:** |
| [ ] Foam (for comfort only) | [ ] Lowzone (memory foam low to med risk) | [ ] Flotech solution (fluid medium to high risk) |
| [ ] WCS to advise (existing skin damage). Describe skin damage including category and site and give waterlow score: |

|  |
| --- |
| **Select accessories from range below:** |
| [ ] Stump board:  | [ ] Left  | [ ] Right |
| [ ] ELR:  | [ ] Left  | [ ] Right |
| [ ] Bexhill armrest  | [ ] Left  | [ ] Right |
| [ ] Waistbelt |

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| --- |
| **Details of prescriber:** |
| **Name:**  | **Email:** |
| **Profession:** | **Base & Tel. No:** |
| **Signed:** | **Date:** |