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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

Must be fully completed

Title:		Forename:			Surname:		
Date of birth:		Gender:		NHS number:			
Address:					Post code:		
Home tel:			Mobile:				
Email:							
Interpreter required?	No		Yes, for the following language:				

2. General Practitioner details

Must be fully completed

GP name:			GP number:		
Address:				Post code:	
Main tel:		Email:			

3. Alternative contact details

Must be fully completed

Name:			Relationship:		
Address: (If different to section 1)				Post code:	
Email:					
Home tel:		Mobile:			
Is the person named in this section the primary contact for this patient?	Yes		No		

Address: Leicester Specialist Mobility Centre, 17a Meridian East, Leicester, LE19 1WZ
Tel: 0116 296 8400 | **Email:** opcare.wheelchairservices@nhs.net | **Web:** www.opcare.co.uk

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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 your referral.

Is this an urgent case (e.g. for a terminal illness or a hospital discharge)?	Yes		No	
N.B.: We reserve the right to reassess the patient's priority.				
If required for hospital discharge, please state the date:				
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, and for how long each time? (E.g. "Twice a day - 3 hours each")							
Do you have a suggested cushion for this patient?	Yes		No				
If yes, please specify:							
Will the patient be able to maintain sitting balance in the wheelchair?	Yes		No				
Is there a history of pressure sores?	No		Yes, current		Yes, historical		
For 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 manual chairs should be completed on the separate manual chair referral form							

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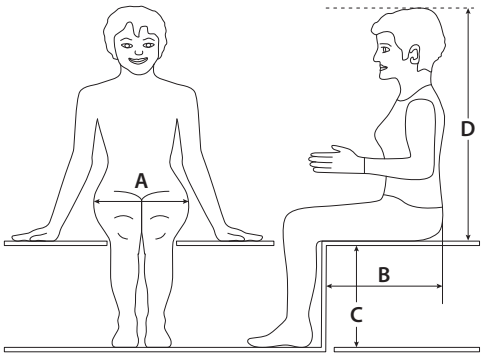
6. Assessment details

Continued from page 3

Taking meassurements:

- 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
- If you are unable to complete these measurements, please cross through this section and request that the patient is assessed by the wheelchair service.



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	

- **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	
Would the patient like to discuss using their Personal Wheelchair Budget?	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:

Referrer's signature:		Date:	

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10. Information required from patient's GP

Must be fully completed

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, or do you believe that doing so would put the patient at risk? Yes ☐ No ☐

Comment:

B. Is the patient affected by epilepsy, or blackouts? Yes ☐ No ☐

If so, has the patient had a seizure, blackout, etc. in the past year? Yes ☐ No ☐

Comment:

C. Has the patient been prescribed any medication that affects their ability to drive? Yes ☐ No ☐

Comment:

D. Is the patient visually impaired? Yes ☐ No ☐

Comment:

E. Does the patient have any mental health problems that would affect their ability to safely operate a powered wheelchair? Yes ☐ No ☐

Comment:

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10. Information Required from patient's GP

Continued from page 6

F. Does the patient suffer from any perceptual deficits, e.g. neglect?	Yes		No	
Comment:				
G. Are you aware of any other conditions which would affect the patient's safe use of a powered chair?	Yes		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:	

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