Northamptonshire Wheelchair & Specialist Buggy Referral Form

Important Recommendations

- Do not complete from an internet browser due to incompatibilities, (right click and save file to secure location).
- Use the latest Adobe Acrobat DC Reader.
- **Use the submit button at the bottom of this form to send the data to the service.**
- Dates must be keyed in full DD/MM/YYYY format.
- Signature is not mandatory at this stage but may be required in the future, register for a Digital Signature.
- This form should be completed by the Service User's Healthcare Professional for wheelchairs or buggy requests.
- Enquiries to cabsl.northamptonshirewheelchairservice@nhs.net Tel **01536 511025**

Service User Details		**GP Details**	
NHS Number		GP Name	
Title		Nat GP Code	
Forename(s)		Postcode	
Surname		Tel No.	
Date of Birth	(DD/MM/YYYY)	Date	
Gender			
House Name			
Address 1			
Address 2			
Town			
County			
Postcode			
Email Address			
Telephone No		Mobile No	

Delivery Address (If different from above)							
House Name							
Address 1							
Address 2							
Town							
County							
Postcode							
Email Address							
Telephone No			Mobile No				
Preferred method of communication	Phone	◯	Email	◯	E-Consultation	◯	
Ethnicity							
Main Language			Interpreter Required	Yes	◯	No	◯

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Religion					
Disability / Condition					
Relevant Medical Details					
Critical Case (e.g. terminal illness) , provide reason below				Yes ◯	No ◯
Essential for hospital discharge?				Yes ◯	No ◯
Date of discharge (DD/MM/YYYY)					
Is this person already in possession of an NHS wheelchair?				Yes ◯	No ◯

Details of Prescriber (if different to GP)

Name		Address	
Tel No			
Email Address			
Profession		Postcode	

Would you like to be present at the assessment?	Yes ◯	No ◯
Comments		
Date		

Assessment Details: Wheelchair

What is the person's walking ability within the home?					
What is the person's transfer method?					
How often will the wheelchair be used?					
Is the person required to sit in their wheelchair when travelling in a vehicle?				Yes ◯	No ◯
Is the wheelchair required for	Indoor	◯	Outdoor ◯	Both	◯

Assessment Details: Cushion

Is standard foam cushion adequate?	Yes ◯	No ◯
If yes please select height		
How long on average will the person be sitting in the wheelchair?		
Suggested cushion?		

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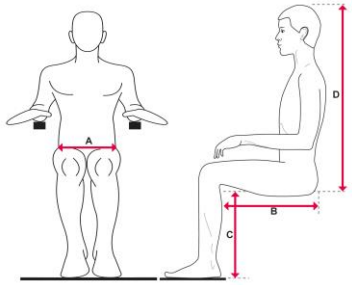
What is the maximum duration the person will sit in the wheelchair in one session?							
Can the person maintain sitting balance in the wheelchair?					Yes	◯	No ◯
Person's tissue status							
Previous pressure ulcer(s)					Yes	◯	No ◯
Site		Category					
Present pressure ulcer(s)					Yes	◯	No ◯
Site		Category					
Continence status							
Who will maintain and monitor cushion							
Waterlow score							
Type Required							
Does the person have limited walking ability, likely to last in excess of six months?					Yes	◯	No ◯
Self-Propelling		Attendant Wheelchair					
Powered Wheelchair		Buggy (Comments)					

Measurements

Height	Feet		Inches		Metres	
Weight	Stone		Lbs		Kilos	
Weight Trend	Stable	◯	Increasing	◯	Decreasing	◯

In sitting upright:	Inches	cm
A = Hip width		
B = Back of buttocks to back of knee		
C = Back of knee to sole of foot		
D = Seat to top of head		



Further Assessment by Wheelchair Service Team				
Is further assessment required	Yes	◯	No	◯
Interested in personal wheelchair budget?	Yes	◯	No	◯
Additional Information				

For powered wheelchairs the medical questionnaire below to be completed by Doctors only.

Please note that we do not provide scooters, powered chairs for outdoor use only or attendant operated powered wheelchairs.

Medical Questionnaire Section				
Please complete the request for medical information, which is needed before an assessment can be arranged for a powered wheelchair for your patient. Please tick the selected answer.				
1. Mobility In your opinion, is this person unable to walk or self-propel a manual wheelchair, or are they medically at risk to do so? Add any comments below	Yes	◯	No	◯
2. Is this patient affected by the following:				
A. Epilepsy/blackouts	Yes	◯	No	◯
Has the patient had a seizure in the past year?	Yes	◯	No	◯
B. Any medication or their side effects Add any comments below	Yes	◯	No	◯
C. Visual impairments, please give details below	Yes	◯	No	◯
D. Mental health problems (relevant to safe wheelchair use) with comments	Yes	◯	No	◯
E. Challenging Behaviour may affect safe use of a powered wheelchair	Yes	◯	No	◯
F. Perceptual deficits e.g. hemianopia	Yes	◯	No	◯
G. Any other conditions that may affect safe use of a powered chair?	Yes	◯	No	◯
3. In my opinion, this individual is medically fit to control a powered wheelchair?	Yes	◯	No	◯
Name				
Designation				

Submit Reset Help

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