

**Shropshire Wheelchair & Posture Service Referral Form**

Guidance for completing this form:

This referral form is for NEW clients/patients – For clients already known to Shropshire Wheelchair & Posture Service, please call to make a re-referral, completion of a referral form is not required.

**Please ensure that all details are filled out and as much information as possible is included to ensure minimum delay.**

Please return this form by email**shropcom.swaps@nhs.net**or address **Shropshire Wheelchair & Posture Service,** **Rehabilitation Centre, Lancaster Rd, Harlescott, Shropshire, SY1 3NJ**

If you have any questions please don’t hesitate to contact us on **01743 444051**

**SHA no:**

**Is the client aware of this referral?** [ ] Yes [ ]  No

**Client’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| Title |  | Surname |  |
| Forename & Middle Name |  | Gender | [ ] Male [ ]  Female |
| Date of birth |  | NHS number |  |
| Ethnicity  |  | Telephone/Mobile number |  |
| Postcode  |  | Email |  |
| Address |  | English speaking? | [ ] Yes [ ]  No |
| If ‘no’ please state language spoken: |  |
| Preferred communication method?  |  |

**Next of kin details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship to client |  |
| Telephone number |  | Best person to contact | [ ] Client [ ]  Next of kin[ ]  Other, please specify:  |

**GP details**

|  |  |  |  |
| --- | --- | --- | --- |
| GP name |  | GP telephone number |  |
| GP surgery |  | GP address |  |

![MC900217366[1]]()

Ver: 02/22

Date:

NHS No:

Client Name:

**Other professionals**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Professional status |  |
| Telephone number |  | Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Professional status |  |
| Telephone number |  | Address |  |

**Please include any more professionals in comments section at the end of the form**

**Risk**

|  |  |
| --- | --- |
| Do you have any knowledge of incidents that may affect staff visiting the client alone (e.g. alcohol misuse, incidence of violence)?  | [ ] Yes [ ]  No (if ‘yes’ please provide brief details)Details:  |

**Medical information**

|  |  |
| --- | --- |
| Diagnosis/ medical history andDate of diagnosis |  |
| Does the client have sensory impairments? i.e. visual, hearing, perceptual difficulties | [ ] Yes [ ]  No (if ‘yes’ please provide brief details)Details: |
| Does the client have cognitive difficulties? | [ ] Yes [ ]  No (if ‘yes’ please provide brief details)Details: |
| Does client have any communication difficulties?  | [ ] Yes [ ]  No (if ‘yes’ please provide brief details)Details: |

**Referral information**

|  |  |
| --- | --- |
| Client’s transfer technique: | [ ] Independent [ ]  Assisted [ ]  HoistedDetails: |
| Current equipment: (do they have a wheelchair? Private/NHS) |  |
| Time spent in the wheelchair:  |  |
| How does/will client mobilise indoors? |  |

 ****

Ver: 02/22

Date:

**Environment**

NHS No:

Client Name:

|  |  |  |  |
| --- | --- | --- | --- |
| Who does/will the client live with? |  | Type of accommodation |  |
| Internal access door widths |  | External access(e.g. lift/ ramp/steps) |  |
|  Any restrictions in the home environment?  |  |

**Pressure care**

|  |  |
| --- | --- |
| How long will the client sit in the wheelchair at any one time? (approx.) |  |
| Does the client have any current/history of pressure sores?  | [ ] Yes [ ]  No Details:  |
| Does the client have any current issues with continence? (Catheterised etc.) | [ ] Yes [ ]  No Details: |
| Can the client independently weight shift to relieve pressure? | [ ] Yes [ ]  No Details: |

**Client’s measurements**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **m/cm** | **ft/in** |  | **kg** | **st/lb** |
| Height |  |  | Weight |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **cm** | **in** |  | **cm** | **in** |
| Hip Width (A) |  |  | Upper Leg Length (B) |  |  |
| Lower Leg length (C) |  |  | Base to shoulder (D) |  |  |

****

![MC900217366[1]]()

Ver: 02/22

Date:

NHS No:

Client Name:

**What is the assessment needed for?**

[ ]  Cushion/Pressure issues

[ ]  Powered wheelchair

Tick as many boxes as necessary, indicating priority:

[ ]  Buggy

[ ]  Attendant Pushed Wheelchair

[ ]  Postural management

[ ]  Self-Propelled Wheelchair

[ ]  Voucher

[ ]  Left hand controls

[ ]  Right hand controls

**Please tick appropriate left or right hand controls**

**What is the wheelchair needed for?**

[ ]  2: Semi-permanent/occasional indoor need

[ ]  1: Permanent mobility needs (i.e. NO walking ability)

[ ]  3: Regular social needs (for day centre/part of care package)

[ ]  4: Medical Emergency

|  |  |  |
| --- | --- | --- |
| **ANY COMMENTS OR FUTHER INFORMATION:**(**Include hospital discharge date**, **days client may not be available etc**.) |  | Ver: 12/19 |
| **Delivery options**[ ]  Self-collect - Shrewsbury (Shropshire Community Centre)[ ]  Deliver (if you select this option, it will extend the lead time)If address is different from client’s usual residence please include here: **Referrer information**

|  |  |  |  |
| --- | --- | --- | --- |
| Completed by: |  | Date: |  |
| Signed: |  | Authorised referrer number: |  |
| Profession: |  |
| Address: |  |
|  |
| Email: |  | Telephone number: |  |

 |  |  |

![MC900217366[1]]()

Ver: 02/22

Date:

NHS No:

Client Name:

**For office use only**

![MC900217366[1]]()

Ver: 02/22

**Triage notes:**

**Clinician: Date:**

Ver: 01/20