Wheelchair Service
Millbrook Healthcare
22 Meadow Road,
Kettering
NN16 8TL

Millbrook HEALTHCARE

NORTHAMPTONSHIRE WHEELCHAIR SERVICE REFERRAL FORM

Wheelchair Service Tel: **0333 999 0890**
Wheelchair Service Fax: **0333 999 0891**

IMPORTANT PLEASE READ BEFORE COMPLETING THIS REFERRAL
All parts of this referral must be completed. The form should then be returned to the address above. Incomplete referrals will be returned resulting in an unnecessary delay in provision of a wheelchair. Referrals are accepted from qualified health professionals, who can provide sufficient information, commonly Consultants, Registrar, House Officers, GP's, District Nurses, Occupational Therapists, Physiotherapists, and Health Visitors.

Is your client aware of this referral?	Yes ☐	No ☐				
			Referral Type	New ☐	Re-referral ☐	
Referral date			**Title**			
Surname			**D.O.B**			
Forenames			**Gender**	Male ☐	Female ☐	
Home Address			**Delivery Address (if different)**			
Phone			**Mobile**			
Ethnicity			**NHS No**			
Client Email Address			**Preferred Contact**	Email ☐	Post ☐	
				SMS ☐	Phone ☐	
Languages Spoken			**Interpreter Required?**	Yes ☐	No ☐	
Next of Kin			**Next of Kin Contact**			
GP Details (GP name, address and number)			**Any Open Alerts / Warnings / Risks**			

NURSERY / SCHOOL / COLLEGE / DAY CENTRE / OTHER - if attended

Name / address:	

CARER INFORMATION

Name:	
Relevant carer information (if applicable)	

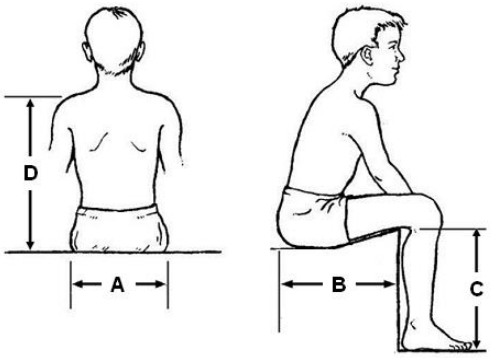
CLINICAL INFORMATION

Height		m cm	*or*		ft. in	Weight		kg	*or*		st lb

(Height and weight are essential information)

Measurements (must be completed for all prescriptions **and** all referrals)

A: Seat Width:		
	Left	**Right**
B: Seat Depth:		
C: Lower Leg:		
D: Shoulder Height		



Primary Diagnosis						
Other Disabilities (including visual problems)						
Does the client have epilepsy?	Yes	☐	No	☐	*If yes when was their last seizure?*	
How will the client transfer?						
Does the client have a skeletal deformity that affects their ability to sit?	Yes	☐	No	☐	*If yes, please detail below*	

Mental Capacity Act

Has your client consented to this referral?	Yes	☐	No	☐

Please demonstrate that under the Mental Capacity Act this referral is being made in the best interests of the client/patient.

If '***No***', please attached a copy of the completed MCA assessment and state the reasons why this referral is in the person's best interests.

USE OF THE WHEELCHAIR

How often each week will the wheelchair be used?

Every Day	☐	4-6 days per week	☐	1-3 days per week	☐	Not every week	☐

How long will the wheelchair be used on each occasion?

Over 8 hours	☐	Between 4 - 8 hours	☐	Between 2 - 4 hours	☐	Less than 2 hours	☐

How will the wheelchair be used?

Indoors Only	☐	Outdoors Only	☐	Indoors and Outdoors	☐

INFORMATION ABOUT EXISTING EQUIPMENT

Details of existing wheelchair equipment (please state if private / NHS funded / voucher)

Details of relevant other current equipment (including static seating and 24 hour management)

REFERRAL TYPE

Manual	☐	Self propelled	☐	Transit	☐	
Powered	☐					
Postural supportive buggy	☐	Other – Please specify	☐			

Please state any further information / clinical reasoning below.

If the referral is for a self propelled wheelchair, is the client medically fit to self propel?	Yes ☐	No ☐	

PRESSURE MANAGEMENT

Is a standard cushion required?	Yes	☐	No	☐	
Pressure cushion required?	Yes	☐	Risk assessment attached	☐	
Has the client had a history / previous pressure sores?	Yes	☐	No	☐	*If yes, please detail below*

Please state below any trials with pressure cushion and any pressure mapping.

HOSPITAL DISCHARGE DETAILS

Is the equipment required for a hospital discharge?	Yes	☐	No	☐
What is the estimated date of discharge?	DD / MM / YY			

If equipment is required to facilitate a hospital discharge, please provide further details

TRANSPORT DETAILS

Will the person be transported in the wheelchair in a vehicle?	Yes	☐	No	☐
Will the equipment be transported in school transport?	Yes	☐	No	☐
If known Which area provides your school transport?				

If you answered yes, please provide details (type of vehicle, adaptations, access)

ENVIRONMENTAL DETAILS (If known)

Internal environmental considerations and restrictions
Where possible please state sizes of restriction

Narrow Doors	☐	Narrowest Size	
Narrow Corridors	☐	Narrowest Size	
Raised Thresholds	☐	Height	
Lift at Home	☐	Size	
Lift at School / Office	☐	Size	
Steps to Access	☐	Number of Steps	
Tight internal Turns	☐	Where are the restrictions?	

External environmental restrictions
Please state any external restrictions below (i.e. hills, grass, gravel, uneven ground, steep driveway, lack of dropped kerbs)

REFERRED BY

Name		Position	

Please note that referrals are accepted from Consultants, Registrar, House Officers, GP's, District Nurses, Occupational Therapists, Physiotherapists, and Health Visitors only.

Would you like to attend the assessment *(Please note we will endeavour to invite you however due to arrangements of clinicians appointments this cannot always be guaranteed)*	Yes	☐	No	☐

Address	Phone	
	Mobile	
	Email	

Signature of referrer	
Referral copied to	e.g. Carers / School / GP/ OT Notes / PT Notes / Other agencies