Wheelchair Service
Millbrook Healthcare
Unit D,
Armada Point
Estover Road
Plymouth
PL6 7PY

PLYMOUTH AND WEST DEVON WHEELCHAIR SERVICE REFERRAL FORM

Wheelchair Clinical Service Tel: **0845 894 0634**
Wheelchair Maintenance Service Tel**: 0845 894 0635**
Wheelchair Service Fax: **0845 481 8567**

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 or social care professionals, who can provide sufficient information, commonly Consultants, GP's, Nurses, Social Workers, Teachers, Occupational and Physiotherapists,

Is your client aware of this referral?	Yes ☐	No ☐					
Request	Referral ☐	Prescription *(Accredited prescribers only)* ☐		**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)

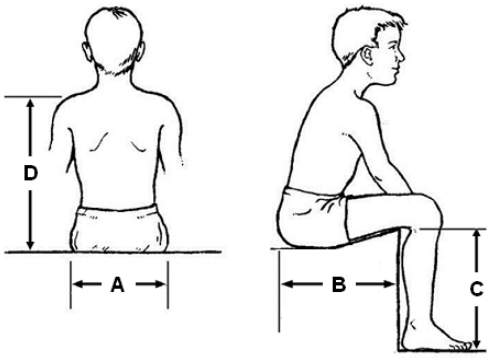
CLINICAL INFORMATION

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*

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 ONLY - TYPE OF CHAIR REQUIRED

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

Please state any further information / clinical reasoning below.

PRESCRIPTIONS ONLY – only complete this part if prescribing a chair (see below)

Prescriber must have attended accredited prescribers training within last 3 years
Please select size and type of wheelchair required (failure to select will mean the prescription is treated as a referral and will delay provision)

Self propelled	☐	15 x 16”	☐	16 x 16”	☐	17 x 17”	☐	18 x 17”	☐
Transit	☐	19 x 17”	☐	20 x 18	☐	22 x 18	☐	24 x 18	☐
		Rea Azalea	☐						
		Please confirm size of Rea Azalea							

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 or previous pressure sores?	Yes	☐	No	☐	*If yes, please detail below*	

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

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	☐			
Which area provides your school transport?	Cornwall	☐	Plymouth	☐	Exeter	☐	

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

ENVIRONMENTAL DETAILS

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

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

Wheelchair Accreditation Number
Essential for prescriptions

Address

Phone

Mobile

Email

Signature of referrer

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