Millbrook
HEALTHCARE

Application for Provision of a Wheelchair – East Sussex Wheelchair Service
This form should only be used when a patient needs a wheelchair because of PERMANENT illness or disability. For temporary disability, please refer to the Red Cross

IMPORTANT PLEASE READ BEFORE COMPLETING THIS REFERRAL
All parts of this referral must be completed. The form should then be returned to the address below.
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.

Referral Type	New	☐	Re-referral	☐

Referral date		**Title**				
Surname		**D.O.B**				
Forenames		**Gender**	Male	☐	Female	☐
Home Address		**Delivery Address (if different)**				
Phone		**Mobile**				
Email		**NHS No**				
Ethnic Group		**Preferred Contact**	Email	☐	Post	☐
			SMS	☐	Phone	☐
Preferred Method of Communication						
Languages Spoken		**Interpreter Required?**	Yes	☐	No	☐
Next of Kin		**Next of Kin Contact**				
Any Open Alerts / Warnings / Risks		**Any Open Alerts / Warnings / Risks**				

GP Name		**Telephone No:**	
Surgery		**Practice Code**	

CLINICAL INFORMATION

Primary Diagnosis	
Other Disabilities (including visual problems	

(Height and weight are essential information)

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

INFORMATION ABOUT EXISTING EQUIPMENT

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

REFERRAL ONLY - TYPE OF CHAIR REQUIRED

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

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

Please state any further information / clinical reasoning 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	☐

Does the client have epilepsy?	Yes	☐	No	☐	If yes when was their last seizure?	
How will the client transfer?	Independently	☐	Assisted	☐	Hoisted	☐

Does the client have a skeletal deformity that affects their ability to sit?	Yes	☐	No	☐

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.

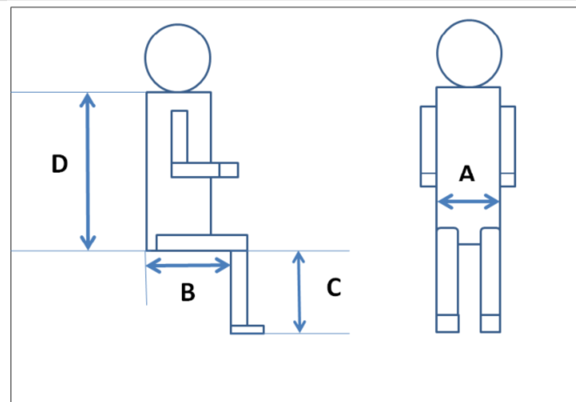
If '***No***', please attached a copy of the completed MCA assessment and state the reasons why this referral is in the person's best interests.

Part 2
PRESCRIPTIONS ONLY (prescriber must have attended accredited prescribers training)
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	☐

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

A: Hip Width		
B: Leg Length	Right	
	Left	
C: Lower Leg	Right	
	Left	
D: Base to top of shoulder		



PRESSURE MANAGEMENT

Is a standard cushion required?	Yes	☐	No	☐
Pressure cushion required	Yes	☐	Pressure Risk Scale – *Braden, Waterlow or Purpose T (please attach)*	☐
Has the client suffered previous pressure sores?	Yes	☐	No	☐

If yes, please detail below, including any cushions trialled

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 equipment be transported in a vehicle?	Yes	☐	No	☐
Will the equipment be transported in school transport?	Yes	☐	No	☐

If 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	

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 — Yes ☐ No ☐

(Please note we will endeavour to invite you however due to arrangements of clinicians appointments this can not always be guaranteed)

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

Please return completed form to:

East Sussex Wheelchair Service Unit 8 & 9 Alder Close Eastbourne East Sussex, BN23 6QF	Tel 0333 0035619 Fax 0333 0035623 Email esh-tr.millbrookcaws@nhs.net