

Application for Provision of a Wheelchair – Somerset Wheelchair Service
 This form should only be used when a patient needs a wheelchair because of **PERMANENT** illness or disability.

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.

GP Details

GP Name		Telephone No:	
Surgery		Practice Code	J

Is your client aware of this referral?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Request	Referral	<input type="checkbox"/>	Prescription	<input type="checkbox"/>	
Referral date			Referral Type	New	<input type="checkbox"/>
Surname			Title	Re-referral	<input type="checkbox"/>
Forenames			D.O.B		
Home Address			Gender	Male	<input type="checkbox"/>
				Female	<input type="checkbox"/>
			Delivery Address (if different)		
Phone			Mobile		
Email			NHS No		
Ethnic Group			Preferred Contact	Email	<input type="checkbox"/>
				Post	<input type="checkbox"/>
				SMS	<input type="checkbox"/>
				Phone	<input type="checkbox"/>
Languages Spoken			Interpreter Required?	Yes	<input type="checkbox"/>
				No	<input type="checkbox"/>
Next of Kin			Next of Kin Contact		
Any Open Alerts / Warnings / Risks					

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

Name:

Address:

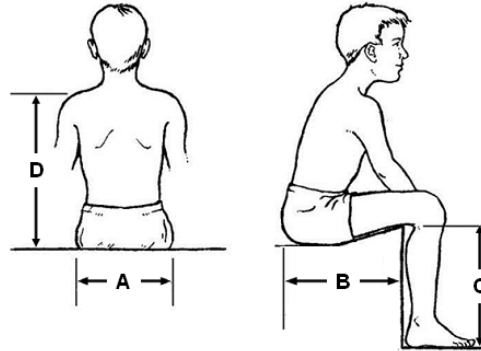
CLINICAL INFORMATION

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?

Independently Assisted Hoisted

Does the client have a skeletal deformity that affects their ability to sit?

Yes No

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

REFERRAL ONLY - TYPE OF CHAIR REQUIRED

Manual Self propelled Transit

Powered

Posturally supportive buggy Other – Please specify

Please state any further information / clinical reasoning below.

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

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 suffered 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 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	<input type="checkbox"/>	Narrowest Size	
Narrow Corridors	<input type="checkbox"/>	Narrowest Size	
Raised Thresholds	<input type="checkbox"/>	Height	
Lift at Home	<input type="checkbox"/>	Size	
Lift at School / Office	<input type="checkbox"/>	Size	
Steps to Access	<input type="checkbox"/>	Number of Steps	
Tight internal Turns	<input type="checkbox"/>	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

(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

Please return completed form to:

Wheelchair Service

Millbrook Healthcare
Unit J, Monument View
Chelston Business Park
Wellington
Somerset
TA21 9JF

Tel 0333 003 5621

Fax 0333 003 5622

Email

Somersetwheelchairservice@millbrookhealthcare.co.uk