Application for Provision of a Wheelchair – Hertfordshire 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**	

Is your client aware of this referral? Yes ☐ No ☐

Request	Referral	☐	Prescription	☐	**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 ☐	
Languages Spoken					**Interpreter Required?**	Yes ☐	No ☐
Next of Kin					**Next of Kin Contact**		

Any Open Alerts / Warnings / Risks	Any Open Alerts / Warnings / Risks

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

Name:

Address:

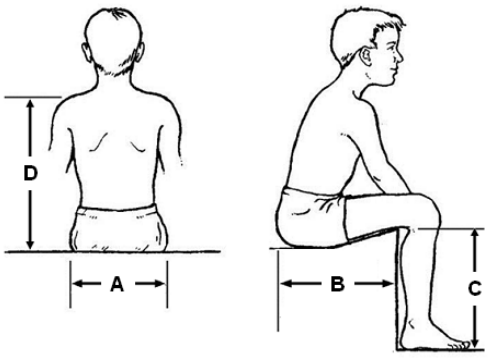
CLINICAL INFORMATION

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”	☐
		Tilt-in-Space	☐						
		Please confirm size of Tilt-in-Space							

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)

ENVIORNMENTAL 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 *(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:

Hertfordshire Wheelchair Service
Millbrook Healthcare
Unit j (Swiftfield), City Park
Watchmead
Welwyn Garden City
Hertfordshire
AL7 1LT

Tel **0333 234 0303**

E-Mail hertswcs@millbrookhealthcare.co.uk