

Referral for an NHS POWERED wheelchair from Somerset Wheelchair Service

This form should only be used when your client needs a wheelchair because of a **PERMANENT** illness or disability which affects their **mobility** inside their own home

Powered wheelchairs are either Class II or Class III medical devices; by their nature (ie. heavy equipment travelling at some speed under power), the risk of use is higher than with a manual wheelchair. As any powered wheelchair provided by an NHS funded service is on loan to the service user, the service is obliged to ensure the safety of the service user and of others sharing the home and of pavement users (if applicable) before issuing a power chair. For this reason, strict criteria must be met (eg. environmental, independent use, safe control). If you believe this may not be the case for your client, please contact the Wheelchair Service for advice, and for possible signposting to other organisations.

**PLEASE NOTE: This form MUST be completed by an appropriate Health Service professional.
Please complete all 4 pages in full and send electronically if possible**

Title	Mr/Mrs/Ms/Master/Miss/Other	Ethnic origin	
Surname		First name(s)	
Date of birth		NHS No	
HEIGHT (essential)		WEIGHT (essential)	Gender M / F
Address, inc postcode			
Telephone numbers	1)	2)	
Client e-mail		Nursing / Res Home?	Yes / No
Next of kin name (NOK)		Relationship	
NOK Tel No		NOK e-mail	
First contact for Wheelchair Service		Reason client not first contact	
GP DETAILS (essential)			
GP Name		Tel	
Surgery		E-mail	
Address inc postcode			

SCHOOL OR COLLEGE ATTENDED (if appropriate)			
Name and address inc postcode		Tel	
		E-mail	
DIAGNOSES inc impact on mobility			
REASON FOR REFERRAL (what will your client be able to do that s/he is not able to now?)			
REQUEST IS FOR (please tick)			
Indoor only powered wheelchair (EPIC)		Please note that outdoor-only powered wheelchairs are not provided by the Wheelchair Service under any circumstances, including for use in places of education, work or leisure	
Indoor-outdoor powered wheelchair (EPIOC)			
How far can your client walk inside their own home?			
How far can your client self-propel inside their own home?			
Has your client been diagnosed with epilepsy?			Yes / No
Has your client experienced seizures, blackouts or other loss of consciousness in the past 12 months			Yes / No
Does your client comply with DVLA requirements for motor vehicle driving concerning epilepsy or other causes of loss of consciousness?			Yes / No
Do you feel that your client has the cognitive, perceptual, motor and visual skills required to operate a powered wheelchair independently?			Yes / No
Does your client have the capacity to understand and comply with the Highway Code Sections 1 to 46 for pedestrians and powered scooters/wheelchairs?			Yes / No
Does your client take any medication which has side effects such as drowsiness, or that would lead you to advise them against driving or operating machinery?			Yes / No
Further details:			
MENTAL CAPACITY ACT (MCA) Has your client consented to this referral?			Yes / No
If no , please attach a copy of the MCA Assessment, or state reason why this referral is in your Client's best interest			
CONSENT			
Does your client consent for information to be shared with you by the Wheelchair Service?			Yes / No
Does your client give consent for you to be invited to appointments?			Yes / No
Are there professionals or others that your client would like to be invited to their appointments?			
If yes , please provide contact details:			

FUNCTIONAL ABILITY , e.g. mobility (distance / aids used), transfers, self-care etc.:					
DOES YOUR CLIENT HAVE ANY KNOWN SKELETAL DEFORMITY?					Yes / No
If yes , please provide further details:					
VISION / HEARING / COMMUNICATION					
CONTINENCE					
HAVE YOU IDENTIFIED ANY RISKS (including safeguarding)?					Yes / No
If 'Yes' , please provide further details					
THE WHEELCHAIR					
HOW OFTEN WOULD THE POWERED WHEELCHAIR BE USED? (please tick):-					
Daily	<input type="checkbox"/>	More than 4 days per week	<input type="checkbox"/>	Less than 4 days per week	<input type="checkbox"/>
HOW LONG WOULD THE POWERED WHEELCHAIR USUALLY BE USED AT ANY ONE TIME?					
Full time	<input type="checkbox"/>	4 – 8 hours	<input type="checkbox"/>	Less than 4 hours	<input type="checkbox"/>
WHERE WOULD THE WHEELCHAIR BE USED THE MOST?					
Indoors at home	<input type="checkbox"/>	Outside of home only	<input type="checkbox"/>	Inside and outside home	<input type="checkbox"/>
WILL THE POWERED WHEELCHAIR BE TRANSPORTED IN A VEHICLE?					Yes / No
If yes , please give details:					
CURRENT WHEELCHAIR AND CUSHION PROVISION (including manual wheelchair)					
REASON THAT CURRENT EQUIPMENT IS NO LONGER SUITABLE					
HOME ENVIRONMENT					
Are there any factors that need to be considered if using the wheelchair indoors, eg. narrow doorways, difficult or steep access, internal steps, insufficient turning circles etc?					

SUPPORT NETWORK			
Does the client have a regular carer?	Yes / No	If Yes , are they resident at the same address?	Yes / No
Frequency of carer visits per day:			
Are there any factors that need to be considered about the carer?			Yes / No
If yes , please provide further details:			
PRESSURE CARE: Please note, pressure relieving cushions may be provided where skin integrity is at risk, but only as part of the 24 hour pressure management care plan			
SKIN INTEGRITY ie. site, size and grade of pressure ulcers (stating if healed or existing), plus other relevant information			
CURRENT PRESSURE CARE MANAGEMENT PLAN			
FURTHER SUPPORTING INFORMATION (eg. static seating or other equipment, social situation)			
REFERRER'S DETAILS - these <u>MUST</u> be completed, including signature, otherwise the referral <u>WILL NOT</u> be processed			
Name		Telephone	
Organisation and address inc postcode		Mobile	
		Email	
Signature of referrer			
Position / designation			
Date of referral			

PLEASE RETURN THIS COMPLETED FORM TO:-
SOMERSET WHEELCHAIR SERVICE
Unit J Monument View; Chelston Business Park; Wellington; TA21 9JF
Telephone: 0333 003 5621 / Fax: 0333 003 5622
Email: somersetwheelchairservice@millbrookhealthcare.co.uk