Northamptonshire Wheelchair Service Referral Form

This must be completed IN FULL by a health professional
Please complete all information to prevent delay in dealing with this referral

Section 1 - Client Details	
Forename:	**NHS no:**
Surname:	**Title:**
Date of Birth:	**Male** □ **Female** □
Home Address:	**Tel No:**
	Mobile No:
Postcode:	**Email Address:**
Ethnic Origin:	**Main Language:**
Client Weight:	**Client Height:**
School/Day centre attended:	
Next of Kin Details:	
Name:	**Contact Details:**
Relationship to Client:	
Client GP Details:	
GP Name:	**GP Surgery:**
Medical diagnosis and relevant medical information:	
Does the client have seizures/blackouts/vacant episodes/epilepsy? Yes □ **No** □ **When was last episode?**	
Are there any risks to lone working?	
Are there any safeguarding concerns?	

Section 2 – Wheelchair Details

Does the client already have a wheelchair?	**Yes** □	**No** □

Details of existing wheelchair equipment:

Please indicate the type of Wheelchair/Assessment you are requesting

Attendant pushed wheelchair	□	
Self-propelled wheelchair	□	
Indoor powered wheelchair	□	
Outdoor powered wheelchair or scooter	□	**(Not provided by NHS)**
Postural support	□	
Pressure relieving cushion	□	
Postural buggy	□	

Will the wheelchair be used

Indoors only □ **Outdoors only** □ **Indoors & Outdoors** □

Section 3 – Clinical Details

How does the client currently mobilise indoors?

How does the client currently mobilise outdoors?

How does the client transfer e.g. bed to chair?

Client can sit on the edge of a bed or plinth: **Unsupported** ☐
With some support ☐
Requires full support ☐

Does the client have / had any pressure ulcers? Please give details:

Client seat width: **Client seat depth:**

Hospital Discharge details:

Is the wheelchair required for hospital discharge?

What is the estimated discharge date and location?

Clinical reasoning:
Please give details of the reason for referral to the Wheelchair Service for specialist assessment:

Section 4 – Consent to Referral		
Has the client consented to this referral?	**Yes** □	**No** □
If not has the referral been made in the clients best interest?	**Yes** □	**No** □

Section 5 – Referrer Details (Health Professional e.g. Doctor, OT, Physio, Nurse)	
Name:	**Designation:**
Address / place of work:	**Contact number:**
Signature:	**Email:**
Would you like to attend the assessment? Yes □ **No** □	**Date:**

Please return form to: Northamptonshire Wheelchair Service
Millbrook Healthcare
22 Meadow Road
Kettering NN16 8TL
Tel: 0333 999 0890

Fax: 0333 999 0891
Email: northants.wcs@nhs.net