Suffolk Wheelchair Service Referral Form

Please complete all sections of this form clearly by hand or in Microsoft Word. ***Delays may occur if information is missing or not clear.*** *Referral forms will be screened by the Wheelchair Service with relation to our service specification and criteria listed below.*

CRITERIA FOR SUPPLY

- Porterage wheelchairs are not supplied to Nursing Homes.
- Wheelchairs are supplied to clients who will be using them **regularly 4 days a week or more.**
- Manual Wheelchair – client has limited walking ability and a long term disability or illness which is likely to be in excess of six months or for a client who is terminally ill.
- Powered Indoor Occupant Controlled Wheelchair – client must be permanently unable to walk and not be able to satisfactorily propel a manual wheelchair and would gain a measure of independence in the home.
- Powered Indoor/Outdoor Occupant Controlled Wheelchair – As above but further local conditions apply (contact wheelchair services if required).
  Note: Occupant Controlled Wheelchairs for outdoor use only are not supplied.

Please note boxes with * are mandatory.

Does the patient meet the criteria of supply? *(please state YES if in agreement)					
Has this referral been made with the client's agreement?				**Yes / No** **Details:**	
Please tick the boxes which apply: ☐ Wheelchair is required to enable hospital discharge. ☐ Client has a rapidly deteriorating condition/receiving palliative care.					
Referrer	Name*		Job Role*		
	Address				
	Postcode		Telephone		
	Email Address				
Client	Surname*		Title*		
	Forename(s)*		D.O.B*		
	Address*		NHS Number*		
	Postcode*		Telephone*		
	Email				
	Does this person live alone?	Y / N	War Pensioner?	Y / N	Have Key safe? Y / N
Carer	Name		Relationship With Client		
	Contact Telephone		Contact Email		
G.P.	GP Practice*		GP Code		

	Address			
	Postcode		Telephone Number	

Medical Diagnosis: Please tick all boxes that apply and list conditions as required.	Neurological ☐ Respiratory ☐ Musculoskeletal ☐ Cardiovascular ☐ Conditions:
Presenting Issues: Please detail current concerns and clinical need for wheelchair provision.	
Reason for Referral: (One must be ticked)	☐ Self-Propelling Assessment (Manual wheelchair) ☐ Pushed by attendant assessment (Manual wheelchair) ☐ Powered **indoor** occupant controlled wheelchair Assessment ☐ Powered **indoor/outdoor** occupant controlled wheelchair assessment ☐ Buggy Assessment ☐ Personal Wheelchair Budget Voucher ☐ Postural Review in wheelchair ☐ Wheelchair Cushion/Pressure Issues

Client's Height*		Client's Weight*	

- **Functional Abilities:**

  Transfer method: How does client transfer in and out of the wheelchair?

  ☐ Independent (standing or sliding transfers)
  ☐ With assistance of carer x 1
  ☐ With assistance of carer x2
  ☐ Standing hoist
  ☐ Sitting hoist with sling

- Walking ability:-

  ☐ Independent (walking without assistance)
  ☐ With equipment (walking using sticks or furniture to help, risk of falling)
  ☐ Unable (cannot walk, may be able to stand, risk of falling)

- How often would the wheelchair be used (approximately, on average)?

  ☐ Occasional (minimum 4 days per week)
  ☐ Every day (7 days per week)

• How long will the client be seated in the wheelchair at any one time? ☐ Less than 2 hrs, ☐ 2-4 hrs, ☐ 4-8 hrs, ☐ More than 8hrs
• Will the client need to be transported in their wheelchair in a vehicle? ☐ Yes, ☐ No

Please clarify the clients' risk of pressure ulcers (PU)?	No issues \No History of pressure damage ☐ At risk\Has History of pressure damage ☐ Pressure Ulcer present ☐ (If ticked, please provide further detail of location and category)	Location of PU and PU category:	

Is the client currently at home?	Y / N	If No, Please give details	

Is there a medical reason why the client cannot attend a wheelchair clinic? *	Y / N	Reason:	

Any other relevant information:	

Best time to contact client:	Anytime ☐ AM (8-12) ☐ PM (12-5) ☐ Evening (after 5) ☐

I confirm that, to the best of my knowledge, the information given is accurate and the above client will use the chair 4 days per week.*	Signature* _____	Date* _____	Job Role* _____

Office Use only:

Did this referral arrive prior to today submission? *	Y / N	Date referral received:	
If acting on behalf of the original referrer, please state name:			

Email: adminwheelchairservices@wsh.nhs.uk