Swindon Wheelchair and Special Seating Service  
Unit 12 – Birch  
Kembrey Park  
Swindon  
SN2 8UU

Tel: 01793 465989  
Email: [gwh.swindonwheelchairservice@nhs.net](mailto:gwh.swindonwheelchairservice@nhs.net)

**Wheelchair service referral form – Confidential**

* Please ensure the client meets sections a-e in section one of the Swindon Wheelchair Service criteria to be considered eligible for provision of equipment
* This form should be used when a client requires a wheelchair because of a long-term, permanent diagnosed physical condition that restricts their mobility
* This form should only be completed by the clients GP, or another health professional
* Sections marked with ‘**\***’ must be completed in full
* Information, referral forms and criteria for issue can be found on our [website](https://www,gwh.nhs.uk/wards-and-services/a-to-z/wheelchair-specialist-seating-service/).

Note: Incomplete, unsigned and/or undated forms will be returned.

1. **Client details\***

|  |  |
| --- | --- |
| NHS Number: | Title: |
| Address and postcode: | Forenames: |
| Surname: |
| Date of birth: |
| Telephone (home): |
| Email address: | Telephone (mobile): |
| Client signature: | |

Has the client consented to this referral? Yes  No

If the client is unable to sign the form, please write ‘verbal consent obtained’ in the client signature box.

If someone has consented on the client’s behalf, or the client is a child, please provide details in the table below:

|  |  |
| --- | --- |
| Name: | Telephone (home): |
| Relationship: | Telephone (mobile): |
| Name: | Telephone (home): |
| Relationship: | Telephone (mobile): |

Does the client have any difficulties making their own decisions?

Yes  No

Who is the next of kin / person available to consult with regarding this referral?

|  |  |
| --- | --- |
| Name: | Telephone (home): |
| Relationship: | Telephone (mobile): |

1. **GP details\***

|  |  |
| --- | --- |
| GP practice: | Name of Dr (if known): |
| Practice address and postcode: | Telephone: |

1. **Referrer details\***

|  |  |
| --- | --- |
| Name: | Profession: |
| Address and postcode: | Telephone (office): |
| Telephone (mobile): |
| Email address: |

Working days:

Mon  Tue  Wed  Thu  Fri

1. **Carer details**

|  |  |
| --- | --- |
| Name: | Relationship to client: |
| Address and postcode: | Telephone (home/office): |
| Telephone (mobile): |
| Email address: |
| Relevant carer needs: | |

1. **Medical history**

|  |
| --- |
| Diagnosis\*: |
| Allergies: |

Does the client have any behavioural needs?

Yes  No

|  |
| --- |
| If yes, please provide details below (include the behavioural support service involved as behaviours will need to be addressed prior to referral to the service): |

1. **Wheelchair use\***

How many days a week will the chair be used?

1 2 3 4 5 6 7

Period sat in the wheelchair:

<2 hours  2-4 hours  over 4 hours

Where will the wheelchair be used?

Indoors only  Indoors and outdoors  Outdoor only

Is the client medically fit to self-propel a wheelchair?

Yes  No  Short supervised

Does the client currently use a wheelchair? Yes  No

|  |
| --- |
| If yes, how often do they use their wheelchair? |

1. **Functional ability\***

Transfer method in/out of wheelchair:

Independent  Supervised  Assisted

|  |
| --- |
| Transfer equipment used: |

What is the client’s ability to walk?

Unable to walk  Indoors only  Short distances

|  |
| --- |
| Waking aids / prothesis / orthosis in use: |
| Postural information (factors affecting a client’s ability to sit in a standard wheelchair): |

1. **A drawing of a person sitting and a person sitting

   Description automatically generatedPhysical measurements in sitting\***

|  |  |  |
| --- | --- | --- |
|  | Measurement | Units (cm/inch) |
| A – Hip width |  |  |
| B – Depth / upper leg length (rear of buttock to back of knee) |  |  |
| C – Lower leg length (Back of knee to bottom of heel) |  |  |

|  |  |
| --- | --- |
| Height (cm): | Weight (kg): |

Note: Accurate weight information is essential for prescription of a wheelchair with a suitable weight limit.

1. **Present condition of client’s skin**

Does the client currently have any pressure ulcers? Yes  No

If yes, please complete the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Location | Category | How long has the ulcer been present? | Cause (if known) | Current treatment |
|  |  |  |  |  |
|  |  |  |  |  |

Does the client require more than a basic foam cushion for use in their wheelchair?

Yes  No

1. **Wheelchair requirements\***

Please select the reason for your referral:

|  |  |
| --- | --- |
| I have completed the Swindon Wheelchair Service accreditation course and I wish to prescribe a basic self-propel wheelchair for my client  Please complete the prescription section below. |  |
| My client requires an assessment by the Swindon Wheelchair Service for a manual wheelchair or buggy |  |
| My client requires an assessment by Swindon Wheelchair Service for an Electrically Powered Indoor Outdoor Chair (EPIOC)  Please ensure the client meets points 1-10 of the Swindon Wheelchair Service criteria for issue of an EPIOC. |  |

I, the referrer, confirm that the information supplied within this form is correct to the best of my knowledge and that the client agrees with the content of this form.

|  |  |
| --- | --- |
| Signature: | Date: |

1. **Wheelchair prescription – Accredited therapists only**

|  |
| --- |
| Accreditation number: |

The client will be sent the wheelchair you prescribe. All wheelchairs will be supplied with a standard 3” foam cushion for adults and 2” foam cushion for children.

Please select the wheelchair seat size you are prescribing:

A black wheelchair with wheels

Description automatically generated16” x 17”

17” x 17”

18” x 17”

19” x 17”

Adult self-propel wheelchair