Swindon Wheelchair and Special Seating Service
Unit 12 – Birch
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**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. **Physical 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 clientPlease 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:

16” x 17” [ ]

17” x 17” [ ]

18” x 17” [ ]

19” x 17” [ ]

Adult self-propel wheelchair