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| --- | --- |
| Client Name:  | NHS no:  |

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| **GSTT Wheelchair Service**Referral Form to be completed by GP or Registered Nurse ONLY**All sections in bold MUST be completed. If not completed, the referral will be returned.** |

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| **SECTION 1** | **CLIENT DETAILS** |
| **Surname**:  | **DOB**: // | **Date of referral**: //**HEIGHT & WEIGHT**:Height:    Weight:  Measured [ ]  OR Estimated [ ]  ↓Date measured: //Weight trend:Stable [ ]  Upward [ ]  Downward [ ]  |
| **Forename**:  | Male [ ]  Female [ ]  |  |
| **Address**:  |  |
|  |  |
|  | **Post code**:  |  |
| **Home Tel**:  | **NHS No**:  |  |
| Alternative contact / NOK:  |  |
|  |  |
| Delivery Address (if different to above):  |  |
|  |  |
| First language:  | Interpreter required? No [ ]  Yes [ ]  |  |

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| **SECTION 2** | **REFERRER & GP DETAILS** |
| **REFERRED BY**:Name: Profession: Address: Tel: Fax: Email: Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **GP DETAILS**:GP name: Address: Tel: Fax: Email:  |

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| **SECTION 3** | **DIAGNOSIS & REASON FOR REFERRAL** |
| **DIAGNOSIS & PMHx**:  |
| **Is client inpatient?** **No** **[ ]  Yes** **[ ]  Discharge date (mandatory if inpatient)**: //***\*\*\* If no discharge date, the referral will be returned.\*\*\**** |
| **REASON FOR REFERRAL** |
| 1. **New Wheelchair User** **[ ]**
 |
| 1. **Current Wheelchair User** **[ ]**

**Current Wheelchair Equipment:** **Reason for review:**  |
| **Do you have any knowledge of incidents that may affect staff visiting client alone (i.e. alcohol misuse, incidence of violence, etc.) Yes** **[ ]  No** **[ ]** Details:  |

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| --- | --- |
| Client Name:  | NHS no:  |

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| **SECTION 4** | **FUNCTIONAL ABILITY / IMPAIRMENT** |
|  | **Comments** |
| **Current medical status** | Stable [ ]  Deteriorating [ ]  Improving [ ]       |
| **Mobility indoors**  | *Details (e.g. walking aids, distance):*  |
| **Mobility outdoors** | *Details (e.g. walking aids, distance):*  |
| **Pressure areas** | *Details (e.g. grade, location, duration of sores):*  |
| **Use of arms** | *Details (e.g. ROM, strength, to self-propel):*  |
| **Use of legs** | *Details (e.g. contractures, ROM):*  |
| **Cognitive / Perceptual deficits** | Details (e.g. memory, neglect, learning difficulty):  |
| **Visual deficits** | *Details (e.g. hemianopia, glasses):*  |

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| **SECTION 5** | **ENVIRONMENTAL & SOCIAL FACTORS** |
| **SOCIAL FACTORS** |
| Does client live alone? | [ ]  Yes[ ]  No | [ ]  with family [ ]  24 hour care [ ]  Other |
| Is there a care package in place? | [ ]  Yes[ ]  No | *Details (e.g. frequency, number of carers):*  |
| Who will push the wheelchair? | [ ]  User[ ]  Family/Carer |  |
| Does the carer have any health concerns? | [ ]  Yes[ ]  No | *Details:*  |

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| **SECTION 6** | **WHEELCHAIR REQUESTED** |
| **Manual Wheelchair** |
| [ ]  | **Manual Self-Propel Wheelchair***(User will push him/herself in the wheelchair)* | [ ]  Indoor[ ]  Outdoor |
| [ ]  | **Manual Attendant Propel Wheelchair***(User requires an attendant to push him/her in the wheelchair)* | [ ]  Indoor[ ]  Outdoor |
| [ ]  | **Electric Powered Wheelchair** | [ ]  Indoor[ ]  Outdoor | Is client able to walk indoors? | [ ]  No[ ]  Yes – not eligible |
|  |  |  | Is client able to self-propel a manual wheelchair indoors? | [ ]  No[ ]  Yes – not eligible |
|  |  |  | Does the client suffer from epilepsy? | [ ]  No[ ]  Yes – not eligible |
|  | ***N.B. Powered wheelchairs are not supplied for outdoor use only. Only clients who require a powered wheelchair for all indoor mobility may be considered for a powered wheelchair assessment. A full list of the eligibility criteria can be obtained by contacting the Wheelchair Service.*** |

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| **SECTION 8** | **ANY OTHER RELEVANT INFORMATION** |
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| **Return to:****GSTT Wheelchair Service, Bowley Close Rehabilitation Centre, Farquhar Road, London, SE19 1SZ****Telephone: 020 3049 7760 Email: gst-tr.gsttwheelchairservice@nhs.net** |