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| Client Name:  | NHS no:  |

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| **GSTT Wheelchair Service**Referral Form to be completed by Occupational Therapist and Physiotherapist 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)**: //**Discharge destination:** ***\*\*\* Without a discharge date, the referral will be returned.\*\*\**** |
| **REASON FOR REFERRAL** |
| 1. **New Wheelchair User** **[ ]**
 |
| 1. **Current Wheelchair User** **[ ]**

**Current Wheelchair Equipment:** **Reason for review:**  |
| **Alternative seating / Postural equipment in situ** *(e.g. bed positioning, static seating, standing equipment)*: |

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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):*  |
| **Transfers** | *Details (e.g. aid):*  |
| **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):*  |
| **Pelvic alignment** | *Details (e.g. tilt, obliquity, rotation):*  |
| **Head position**  | *Details (e.g. forward flexion, lateral tilt):*  |
| **Sitting balance** | *Details (e.g. static & dynamic):*  |
| **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** |
| **ENVIRONMENTAL FACTORS** |
| Type of accommodation? | [ ]  Flat[ ]  House[ ]  Other | *Details (e.g. ownership, level):*  |
| Has a home visit been carried out? (Please attach relevant reports) | [ ]  Yes[ ]  No |  |
| Is the home wheelchair accessible? | [ ]  Yes[ ]  No | *Details (e.g. turning space, narrow doorways, steps):*  |
| **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:*  |
| **TYPE OF (ANTICIPATED) USAGE** |
| **Frequency**: | Daily [ ]   | Weekly [ ]  | Monthly [ ]  |
| **Duration**: | 1-4 hours [ ]  | 4-8 hours [ ]  | All day [ ]  |

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| Client Name:  | NHS no:  |

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| **SECTION 6** | **ACTUAL USER MEASUREMENTS** |
| inches [ ]  cm [ ]  |  |
| 1. Hip width
 |  |
| 1. Seat depth
 |  |
| 1. Seat to footplate height
 |  |
| 1. Seat to armrest height
 |  |
| 1. Backrest height (seat to inferior angle of scapula)
 |  |
| 1. Seat to head height
 |  |

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| **SECTION 7** | **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 |
| **Specialist equipment****\*\*\* Please provide clinical reasoning and any further details in Section 8 for request of a specialist assessment and attach any relevant reports.** |
| [ ]  | **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.*** |
| [ ]  | **Tilt-in-space Wheelchair** | *Details (sitting balance and fixed contractures):*  |
| [ ]  | **Customised Seating** |
| **Paediatrics** |
| [ ]  | **Buggy** | **Name of School / Nursery***:*  |
| [ ]  | **Paediatric Wheelchair** |
|  |
| **SEAT SIZE REQUIRED (HIP WIDTH X SEAT DEPTH)** |
| 13”x15” [ ]  | 14”x15” [ ]  | 15”x16” [ ]  | 16”x16” [ ]  | 17”x17” [ ]  | 18”x17” [ ]  | 19”x17” [ ]  | 20”x17” [ ]  |
| Has client been trialled in seat size requested? Yes [ ]  No [ ]   |

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| Client Name:  | NHS no:  |

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| **SECTION 7** | **WHEELCHAIR REQUESTED (continued)** |
| **TYPE OF CUSHION REQUIRED** |
| Comfort [ ]  | Low pressure care [ ]  | High pressure care [ ]  | Postural [ ]  |
| **TYPE OF ACCESSORIES REQUIRED** |
| Bexhill arm support | Left [ ] Right [ ]  | Elevating leg rest | Left [ ] Right [ ]  | Stump board | Left [ ]  Right [ ]  | Crutch holder  | [ ]  |
| Footboard [ ]  | Rear wheel position:[ ]  Forward (active)[ ]  Mid (standard)[ ]  Set back (stable) | Height adjustable arm supports [ ]  |
| Anti-Tips [ ]  | Other:  |
| **Please provide clinical reasoning for any pressure cushion / accessory requested**: |

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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** |