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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** |