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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)**: //  ***\*\*\* 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** |