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| **Tower Hamlets Wheelchair Service****Referral Form – Adults and Children****(for new clients and power chair requests)** | Wheelchair ServiceMile End Hospital275 Bancroft RoadLondon E1 4DGTel: 020 8223 8842Email: wheelchairservice1@nhs.net |
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| **Important Information – Please read before completing Referral Form**Incomplete referrals will be returned resulting in a delay in service provision. Referrals are accepted from health / social care professionals, who can provide sufficient information about the client/request.Powerchair referrals will ONLY be accepted from Occupational Therapists, Physiotherapist or Social Care |

**\*Section A – Client Details and Information \*Mandatory Sections**

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| Referral date |  | Client/carer has agreed to referral [ ]  |
| Surname |  | Title |  |
| Forenames |  | D.O.B |  |
| NHS Number |  | Gender | Male [ ]  | Female [ ]  |
| Mosaic Number |  |  |
| Home Address | Current / Delivery Address (if different) |
|  |  |
| Post code: | Post code: |
| Phone |  | Mobile |  | None [ ]  |
| Ethnicity |  | Email |  | None [ ]  |
| Languages spoken |  | Interpreter required | Yes [ ]  | No [ ]  |
| Preferred contact | Post [ ]  | Email [ ]  | Next of kin name |  |
| Phone [x]  ☐ | SMS [ ]  |
| Next of kin contact  |  | Next of kin languages |  |
| Emergency contact if different from next of kin |  |
| **GP Practice (Practice name, name of GP, full address, phone number)** |
|  | Post code: |
| **Known risks / warnings / alerts for client** | Yes [ ]  (describe below) | None known [ ]  |
| Any safeguarding alerts, mental health problems / challenging behaviour |
| **School / college / day centre / workplace**  | Yes [ ]  (describe below) | Not applicable [ ]  |
| Name/address |  |
| **Parent / carer / care package / placement details** | Not applicable [ ]   |
| Family provide care [ ]  |
| Social Care Funded [ ]   |
| Continuing Healthcare Funded (CHC) [ ]   |
| Name / details |  |
| **Is a wheelchair required for** **Hospital Discharge?** | Yes [ ]  | No [ ]  |
| If yes – what is the discharge date |  |

**Section B – Clinical Information (attach further information if required)**

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| \*Primarydiagnosis and medication |  |
| Other disabilities  | Including any visual disabilities, cognitive impairments etc. |
| \*Epilepsy  | Yes [ ]  | No [ ]  | If yes, when was the last seizure? |  |
| **Current height and weight (essential)** | Date taken: |  |
| \*Height |  | m / cm | or |  | ft / in | \*Weight |  | kg | or |  | st / lb |
| **Measurements (will speed up equipment provision if provided) –Seat size** |
| **A - Hip width**(widest part of hips or thighs) |  | cm/inch |  |
| **B- Upper leg length** (back of buttocks to back of knee) |  | cm/inch |
| **C- Lower leg length**(behind knee to bottom of heel/shoe) |  | cm/inch |
| **D- Shoulder height**(seat to top of shoulders) |  | cm/inch |
| **E- Top of head**(seat to top of head) |  | cm/inch |
| Not applicable [ ]  (specialist customised seating only)  |
| \*Current indoor mobility | Aids used, assistance required, how do they move around at home |
| \*Current outdoor mobility | Aids used, assistance required, how do they move around in the community |
| \*Transfers | Aids used, assistance required  |
| Posture, functional ability | Head and trunk control, joint range limitations, upper limb function |
| Details of relevant equipment currently used | None used [ ]  |
| Existing wheelchairs / scooters, oxygen / suction, static seating, sleep systems etc. |
| Is the client medically fit to self-propel a manual wheelchair? | Not applicable [ ]  | Yes [ ]  | No [ ]  |
| Is the client medically fit to drive a powered chair? | Not applicable [ ]  | Yes [ ]  | No [ ]  |

**Section C – Details of Request (attach further information if required)**

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| **\*How often will the wheelchair be used?**  |
| Every day [ ]  | 4-6 days/week [ ]  | 1-3 days/week [ ]  | Not every week [ ]  |
| **\*How long will the wheelchair be used on each occasion?** |
| Over 8 hours [ ]  | 4 - 8 hours [ ]  | 2 - 4 hours [ ]  | Less than 2 hours [ ]  |
| **\*Where will the wheelchair be used?** |
| Indoors only [ ]  | Outdoors only [ ]  | Indoors and outdoors ☐ |
| **\*Type of wheelchair required** |
| **Manual** [ ]  | Self-propelled [ ]  | Transit chair [ ]  | Buggy [ ]  | Tilt-in-space transit [ ]  |
| **Powered** [ ]  | Right hand drive [ ]  | Left hand drive [ ]  | Other [ ]  (specify below) |
| **Joint Funding** ☐ Is the wheelchair going to be a single seating solution? (e.g a Tilt-in-space instead of rise and recliner). Is the wheelchair the ONLY seat the client sits in? (e.g. wheelchair to be used for Home and/or school?) Would extra features to the wheelchair enable independence (e.g a seat riser)If the referral is for Joint Funding, submit a fully completed Joint Funding- Additional Information Sheet along with this referral – please request this. |
| Aids Details of request/reason wheelchair is required; wheelchair specifications if known |
| Is the environment wheelchair accessible? | Yes [ ]  | No [ ]  (give details below) |
| Width of doors: +15cm for transit chairs, +20cm for self-propelling |
| Will the person remain in the wheelchair when transported in a vehicle? | Yes [ ]  | No [ ]  |

**NB/ A headrest and harness will only be provided if required for posture. This will not be provided by the Wheelchair service if required for transport purposes only.**

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| If yes please tick below those which apply  |
| **Family Car** [ ]  | Not adapted[ ]  | Wheelchair accessible [ ]  |
| **Local Authority** [ ]  |  Tail lift [ ]  | Ramp [ ]  |
| **School transport** [ ]  | Portable ramps [ ]  | Hoist [ ]  |

**\*Section D – Posture / Pressure Management**

|  |  |  |  |
| --- | --- | --- | --- |
| Client at risk of pressure ulcers? | Yes [ ]  | No [ ]  | If yes, please detail below |
| Client has current pressure ulcers? | Yes [ ]  | No [ ]  | If yes, please detail below |
| Can change position independently? | Yes [ ]  | No [ ]  | If no, please detail below |
| Is District Nursing or TVN involved? | Yes [ ]  | No [ ]  | If yes, please detail below |
| Details of posture / pressure ulcer risk / cushion required |

**\*Section E – Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Position |  |
| Would you like to be notified and attend the assessment date? | Yes [ ]  | No [ ]  |
| Team and Address | \*Phone |  |
|  | Mobile |  |
| Post code: | \*Email |  |
| Client/carer agrees that relevant information is shared | Yes [ ]  | No [ ]  |
| Signature of referrer |  |