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| --- | --- |
| **Tower Hamlets Wheelchair Service**  **Referral Form – Adults and Children**  **(for new clients and power chair requests)** | Wheelchair Service  Mile End Hospital  275 Bancroft Road  London E1 4DG  Tel: 020 8223 8842  Email: wheelchairservice1@nhs.net |
|  |  |
| **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**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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  ☐ | | 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)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*Primary  diagnosis 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)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*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.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 | |  | | | |