

**REFERRAL FORM - NHS WHEELCHAIR**

**This form should be used when a patient needs a wheelchair because of permanent illness or disability lasting more than 6 months. This form must be completed by a G.P., District Nurse or Therapist. When fully completed, please send the form to the Wheelchair Service Administration Team:**

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| **KCHT Wheelchair Service**  Administration Team  Norman House  Beaver Business Park  Beaver Road  Ashford. TN23 7SH | **Tel:** 0300 7900128  **Please E-mail the completed form to:**  [kcht.wheelchairservice-kent@nhs.net](mailto:kcht.wheelchairservice-kent@nhs.net)  Service Hours - 09:00 to 17:00 Monday to Friday |
| **DO NOT USE - INTERNAL USE ONLY**  **Ashford**  **Heathside  Aylesham  Canterbury  Medway  Dartford**  **DO NOT USE - INTERNAL USE ONLY** | |

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| NHS No: |  |  |  |  |  |  |  |  |  |  |

**\*Please complete all boxes to avoid unnecessary delays\***

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| Client Details  Title: Mr / Mrs / Miss  / Ms / Master OTHER  :  Forenames:       Surname:  Date of Birth: | |
| Full client postal address:    Postcode: | Alternative Contact/Address/Details:  Name & Relationship to Client:  Address/Details:    Postcode: |
| Telephone No:  Mobile No:  E-Mail: | Telephone No:  Mobile No:  E-Mail: |
| GP Name:  Address:       Telephone Number: | |

Client Ethnicity (From the information you have gained from the client, please indicate by selecting one of the boxes below the client’s ethnicity)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| WHITE | A | British |  |  | ASIAN | H | Indian |  |
| B | Irish |  |  | J | Pakistani |  |
| C | Any other white background |  |  | K | Bangladeshi |  |
|  | | | | | L | Any other Asian background |  |
| MIXED | D | White and Black Caribbean |  |
| E | White and Black African |  |  | BLACK OR BLACK BRITISH | M | Caribbean |  |
| F | White Asian |  |  | N | African |  |
| G | Any other mixed background |  |  | P | Any other Black background |  |
|  |  |  |  |  |  |  |  |
| PATIENT ASKED | Z | Patient asked but declined |  | OTHER ETHNIC | R | Chinese |  |
|  |  |  |  |  | S | Any other ethnic category |  |

Mental Capacity Act

Has the patient/client consented to this referral? YES:  NO:

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| Please demonstrate that under the Mental Capacity Act you are making this referral in the best interests of the client/patient. | If No, Please attach a copy of the completed MCA assessment and state the reasons why this referral is in the person’s best interests. |

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| Is the client already in possession of a NHS Wheelchair?  Yes  - Please complete the Re-Referral section **(Page 4)** No  - Please continue  **If you are completing the Re-Referral Section, please make sure that all the previous fields are completed.** | | | | | | | |
| Does the client have a Private Wheelchair / Temporary loan wheelchair?  Yes  - Please Provide Details: | | | | | | | |
| Client Diagnosis - (Please include any known secondary conditions)    Patient Height/Weight: Height (cm):       Weight (Kg): | | | | | | | |
| Clients Functional Limitations (\*Please provide relevant information/detail below) | | | | | | | |
| Yes\*  No  - Visual Impairment  Yes\*  No  - Perceptual Impairment  Yes\*  No  - Respiratory Limitations  Yes\*  No  - Neurological Impairment  Yes\*  No  - Postural Deformities | | | | Yes\*  No  - Cognitive Impairment  Yes\*  No  - Epileptic Fits  Yes\*  No  - Cardiac Limitations  Yes\*  No  - Pressure management issue | | | |
| Use of Upper Limb - Left | Full | Limited | Nil | Use of Upper Limb - Right | Full | Limited | Nil |
| Use of Lower Limb – Left | Full | Limited | Nil | Use of Lower Limb – Right | Full | Limited | Nil |
| Please give any other relevant information/detail: | | | | | | | |
| Level of Mobility  Can the client walk:  Independently indoors  Independently indoors with walking aid  Mobility restricted outdoors  Unable to walk indoors/outdoors  Comments: e.g. type of walking aid used | | | | | | | |
| Method of Transfer  Independent  Standing  Sliding board  Other:  With assistance of 1  With assistance of 2  Unable to transfer:  Hoisted : Please state type of hoist: | | | | | | | |
| Proposed Use of Wheelchair:  Will the wheelchair be:  Self propelled by client  Pushed by others  Combination  Is the client medically fit to:  Self propel indoors? Yes  No  Self propel outdoors? Yes  No  If not medically fit to self propel do you agree for the wheelchair to be fitted with self propelling wheels to assist carers / allow client to assist / manoeuvre short distances? Yes  No  If pushed by others does the client have a regular carer? Yes  No  Is the carer medically fit to push and lift a wheelchair? Yes  No  How often will the wheelchair be used:  Every Day  Occasional Use  1-2 days a week  3-7days a week  How many hours will the wheelchair be used:  Indoors within the home?  Indoors and outdoors?  Outdoors only?  Outdoors mainly but required to access day centre / regular hospital appointments?  Will the client be transported within their wheelchair secured into a vehicle? Yes  No  Will the client have to lift the wheelchair into a vehicle themselves? Yes  No | | | | | | | |
| Are there any factors about the home which need to be considered eg steps, narrow doorways/ passageways?  No  Yes  Please give details: | | | | | | | |
| Client seating measurements:  Seat Width:       Seat Depth:       Lower Leg Length: | | | | | | | |
| Type of wheelchair requested:  Self propelling wheelchair  Transit manual wheelchair  Voucher for manual wheelchair  Indoor powered wheelchair – issued only where the client is permanently unable to walk, or client is unable to self propel, but can demonstrate increase in independence from a powered wheelchair)  Indoor/Outdoor powered wheelchair – issued only where the client firstly meets the criteria for an indoor powered wheelchair  Postural Seating System mounted on a mobility base  **Please note that the NHS does not provide powered wheelchairs where the need is solely for outside use**  For powered wheelchair provision:  Client hand dominance? Right  Left  Controller to be mounted? Right  Left  Alternative controller mounting please state:    Other Accessories / adaptations / modifications required: (e.g. lap belt, transtibial support, Elevating leg rest)    For pressure relieving cushion please complete the Pressure Cushion Referral Form. | | | | | | | |
| Delivery  Is wheelchair required for hospital discharge or admission avoidance? Yes  - Discharge Date:  To an alternative delivery address? Yes  - Address:  **NOTE: We cannot deliver outside of the our commissioned localities.** | | | | | | | |
| Additional Information  Please provide any other relevant information: | | | | | | | |
| Name of Referrer (please print):  Designation & Employing organisation:    Contact Details:    Telephone Office:       Mobile:       Email:  Signature: Date: | | | | | | | |

**Re-Referrals**

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| Re-Referral section – Please complete this section if the client already has an NHS Wheelchair  Which model of wheelchair does the client currently use?    Reason for Re-referral? Please give full details |
| Name of Referrer (please print):  Designation & Employing organisation:    Contact Details:    Telephone Office:       Mobile:       Email:  Signature: Date: |