![Kent_Community_HealthColA[1]]()

**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 TeamNorman HouseBeaver Business ParkBeaver RoadAshford. TN23 7SH | **Tel:** 0300 7900128**Please E-mail the completed form to:**kcht.wheelchairservice-kent@nhs.netService 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** |

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

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

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| Client DetailsTitle: 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)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 ImpairmentYes\* [ ]  No [ ]  - Perceptual ImpairmentYes\* [ ]  No [ ]  - Respiratory LimitationsYes\* [ ]  No [ ]  - Neurological ImpairmentYes\* [ ]  No [ ]  - Postural Deformities  | Yes\* [ ]  No [ ]  - Cognitive ImpairmentYes\* [ ]  No [ ]  - Epileptic FitsYes\* [ ]  No [ ]  - Cardiac LimitationsYes\* [ ]  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 MobilityCan 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 TransferIndependent [ ]  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. |
| DeliveryIs 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 InformationPlease 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 WheelchairWhich 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:       |