**Kent and Medway Wheelchair Service
GP ONLY – REFERRAL FORM**

 **This form should be used to refer a patient (aged over 36 months) who needs a wheelchair due to a *permanent illness or disability lasting more than 6 months*. This form must be completed by a GP ONLY.**

**When fully completed, please use a secure email address (e.g. NHS net) and send to the Wheelchair Service Administration Team on** **kcht.wheelchairservice-kent@nhs.net****.**

**Note: Patients who have an NHS wheelchair provided by us, can self-refer by phoning 0300 7900128.**

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| ***Mandatory information*** **(*\* essential information to be completed)*** |
| **Patient details**  |
| *\*Title:* | Enter Title | *\*NHS number:*  | Enter NHS No. |
| *\*First name:* | Enter First Name | *\*Date of birth:* | Enter Date of Birth |
| *\*Last name:* | Enter Last Name |  |
| \**Address Line 1:* | Enter Address Line 1 | *\*Main contact method:* | Select Contact Method. |
| Address Line 2 | Enter Address Line 2 | *\*Landline/telephone number:* | Enter Tel. No. |
| Address Line 3 | Enter Address Line 3 | *\*Mobile number:* | Enter Mob. No. |
| Address Line 4 | Enter Address Line 4 | Email address: | Enter E-Mail Address |
| *\*Postcode* | Enter Post Code |  |  |
|  |  |
| *\*Ethnicity* | Select Ethnicity. |
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| *\*Has the patient been informed and consented to this referral?* | [ ]  Client informed and consented.[ ]  Unable to consent but referral made in best interest of the patient. |
| *\*Is this referral needed for admission avoidance?* | [ ]  Yes [ ]  No [ ]  Not known  |
| *The three specific conditions identified below can have a significant impact on the type of equipment that may be provided.* |
| *\*Nature of disability/condition/diagnosis:**Please add any relevant information relating to clinical diagnosis referencing mobility limitations:* | [ ]  Respiratory [ ]  Cardiac [ ]  Epilepsy Enter additional information if relevant |
| *\*If the patient is not medically fit to attend a clinic site please state reason:* | [ ]  Medically fit to attend an assessment in clinic Enter Reason |
| *\*Does this client require a stretcher to attend appointments?* | [ ]  Yes [ ]  No [ ]  Not known: |
|  |
| **GP referrer details** |
| *\*Name of referring GP* | Enter GP Name |
| *\*GP Practice Code* | Enter Practice Code |
| *\*Address* | Enter GP Address |
| *\*Telephone* | Enter Tel. No. |
| *\*Email* | Enter GP E-mail Address |
| *\*Date of referral* | Enter date |
| *We only accept referrals from GPs on this form. Thank you.* |

We retain the right to return this form if the fields marked with a ‘\*’ are not completed. This will result in a delay with the triaging of this referral, the client being given an appointment and will delay the provision of equipment.

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| ***Non-mandatory information****Please complete as much of this section as possible. This information is used to triage the referral and may reduce delays in providing equipment to your patient* |
| Basic wheelchair need:(Do not request a self-propelling wheelchair if the client has any condition or diagnosis that would contra-indicate self-propelling.) | [ ]  Self-propelled (large rear wheels)[ ]  Transit/attendant propelled (small rear wheels) |
| How often has the patient said they would use the wheelchair? | Occasional, 1 to 2 days per week, are not eligible[ ]  Occasional (3 to 6 days per week)[ ]  Full-time user (7 days a week) |
| Has the patient been placed into your CCG area?e.g. an out of area patientIf so, who do you re-charge for any care provided to this patient? | [ ]  Yes [ ]  No [ ]  Not knownSelect Placement Type |
| Details of placing authority or funding body (if known): | Enter Funding Body |
| Reasons for placement (if known): | Enter Placement Reason |
| Patient height: | Enter Height | Select Units. |
| Patient weight: | Enter Weight | Select Units. |
| Does the patient have any known limitations?Please select all that apply | [ ]  Visual[ ]  Perceptual[ ]  Neurological[ ]  Cognitive[ ]  Pressure ulcer | [ ]  Postural deformities(Client may need more specialist staff and therefore provision may take longer) |
| Skin condition: | Select Skin Condition. |
| Please specify grade of pressure ulcer if present:  | Select Grade of Ulcer. |
| Location of ulcer(s): | Enter Location of Ulcer(s) |
| If the patient is required to attend a clinic please advise how they normally access your services, consultant or hospital appointments? | Select Travel Option. |
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| Please give any other relevant information that will help us to manage this referral:The patient’s summary medical history may be attached to this referral. | [ ]  Summary medical history attachedEnter additional information if relevant |

**Information to help you understand the basic eligibility criteria of the Wheelchair Service**

The service provides manual and electrically powered wheelchairs, including specialist seating, to patients who need a wheelchair due to a permanent illness or disability lasting more than six months.

* **Manual wheelchairs:** These are either self-propelled, where the client is able to propel themselves independently, or transit/attendant propelled, where the wheelchair is pushed by a third party.
* **Indoor powered wheelchairs:** These are only issued only where the patient is permanently unable to walk and the patient is unable to self-propel and can demonstrate increase in independence from a powered wheelchair.
* **Indoor/outdoor powered wheelchairs:** These are only issued where the patient firstly meets the criteria for an indoor powered wheelchair and has suitable internal and external environmental access.

**We cannot:**

* provide wheelchairs for users with an **occasional need of two or less days** per week. They are not eligible.
* provide transit/attendant propelled wheelchairs into care homes.
* assess clients who arrive on stretchers for appointments. They would be assessed at home if eligible.
* supply powered wheelchairs for outdoor use only.
* assess for or deliver equipment outside of our commissioned localities.