**West Cheshire Wheelchair Service**

**Referral Form**

This form should only be used when a patient needs a wheelchair because of a permanent illness or disability **(not temporary loan ie, needed longer than six months).** **Please note:** The Wheelchair service is not commissioned to issue attendant pushchairs (transit wheelchairs) to residents living in nursing homes. Care homes are required to provide them to nursing residents.

**All questions must be completed by the referrer.** Once completed this form should be sent to:

West Cheshire Wheelchair Service, Stanney Lane Clinic, Stanney Lane, Ellesmere Port CH65 9AE.

Tel: 0151 514 6454 Email: WCNT.wheelchairreferrals@nhs.net

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| **Consent to referral being made** |
| Does the patient (or the person making decisions on behalf of the patient) consent to referral being made: Yes  No  Have you assessed the patient before making this referral Yes  No |
| **Patient details** |
| Title: Surname: Forename(s): Gender:  Address:  Post code: Email:  Home Tel: Mobile No:  Delivery address (if different from above, used for urgent/direct issues):  Post code: Tel:  Date of birth: NHS Number:  Marital status: Occupation:  Height: (m/cm/ft/in) Weight: (kg/st/lbs) Date last recorded:  Is the patient currently a member of armed forces/reservist/veteran (or close family member): Yes  No  Does the patient have capacity? Yes  No  If no, does the patient have a lasting power of attorney? (for health and welfare): Yes  No  If no, who is making decisions on behalf of the patient: |
| **Accessibility and inclusion information – information you have gained from the patient** |
| Ethnicity: Main Language: Religion:  Does the patient require any interpreter/ translation/ sign language services Yes  No  Please specify:  Does patient report a disability: Physical  Learning disability  Mental health  Hearing  Visual  (please tick all that apply) Other (please specify) Please inform us of any specific communication needs/ adjustments required |
| **GP name and address (or stamp)** |
| Name: Address:  Post code: Tel: |
| **Next of kin details** |
| Name: Relationship: Tel: |
| **Medical history** |
| Current diagnosis:  Details of disability:  Does the patient have any medical contraindication that would affect wheelchair provision eg, unstable angina, exacerbated exertion, uncontrolled fits/blackouts etc? Yes  No  Is the patient on oxygen therapy? Yes  No  Does the patient have dementia/delirium? Yes  No  Does the patient live alone? Yes  No  Current method of mobility indoors: Independent  Independent with equipment  Wheelchair dependent  Postural support: are they able to maintain an upright posture/correct their posture? Yes  No  Has the patient ever had pressure ulcers? Currently  Previously  Never  Is the patient at risk of pressure ulcers? Yes  No  Don’t know  Score: Tool:  Location of pressure ulcer:  Is patient under care of community nurse? Yes  No  Don’t know |
| **Type of wheelchair to be assessed/wheelchair usage** |
| **Manual:**  Required usage: Everyday  Most days  Once a week  Once a month or less  Manual attendant pushed chair (transit)  Self-propelling – I can confirm that the patient does not have any physical or mental health problem that could affect their ability to use a self-propelling wheelchair  How will the user transfer in/out of the wheelchair?  Independently  From the front  Sideways  Hoist  Equipment needed:  **Powered:**  A GP/Consultant MUST refer for these and provide the additional information required (at end of this form) |
| **Travel to Wheelchair Service for assessment** |
| Own transport  Ambulance  Does patient have to remain in a wheelchair whilst travelling in a vehicle? Yes  No |
| **Risk factors** |
| Describe any risk factors there may be to staff eg, aggression, challenging behaviour, unstable mental health conditions, sexually inappropriate behaviour etc: |
| **To be completed by APPROVED PRESCRIBERS ONLY (Those who have attended and completed Wheelchair Service training)** |
| Please specify which wheelchair prescription is required: |
| **Name of referrer** |
| Print name: Signature: Base:  Designation: Tel: Date: |

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| **Additional medical information required for powered wheelchair assessment**  **This must be completed by a GP/Consultant with knowledge of the patient.** |
| *Patients can only be referred for a powered wheelchair for indoor use, however, if the patient is suitable, a wheelchair can be upgraded for additional outdoor use if they meet the required safety criteria.*  The criteria can be found at:  [Wheelchair Service - an introduction - Wirral Community Health and Care NHS Foundation Trust (wchc.nhs.uk)](https://www.wchc.nhs.uk/services/wheelchair/who-we-are/) |
| **Question 1** |
| Does the patient have any physical or mental health problem that you believe could impair their ability to use a powered wheelchair, having the potential to make them a danger to themselves or others, either constant or intermittent?  **Examples include:**  **Neurological:** seizures or loss of consciousness from any cause, including any conditions that cause physical impairment even if intermittent or historical (with dates).  **Disturbance of perception/cognition:** due to hypoglycaemia, hypoxia, mental illness, dementia, alcohol,  hypotension, arrhythmia.  **Visual problems:** macular degeneration, visual field defects.  **This list is not exhaustive.**  Yes  No  If Yes, please comment: |
| **Question 2** |
| Are they prescribed any medication that may impair their ability to operate a powered wheelchair safely?  **Examples include:** any medication included in Drug Driving legislation, opiate or opiate like drugs, hypnotics, benzodiazepines, amphetamine like drugs, other drugs that may interfere with the level of consciousness, speed of reaction or clarity of perception.  Yes  No  If Yes, please comment: |
| **Question 3** |
| Any relevant additional information? (Please attach a detailed medical history with a medication list) |
| **Declaration** |
| This referral requires you to state that the patient is suitable to proceed to an assessment for a powered wheelchair and will be safe to operate one, to the best of your knowledge and belief, based upon your knowledge of the patient and the referral criteria. If you have any concerns, please state in the additional information section.  Signature: GMC Number: Date: |