**Waltham Forest Wheelchair Service**

**Mobility | Posture | Independence**



**Referral Form**

**Please note that ALL FIELDS MUST BE COMPLETED AND SIGNED unless otherwise stated THIS FORM WILL BE RETURNED TO THE REFERRER IF INSUFFICIENT INFORMATION IS SUPPLIED**

|  |
| --- |
| **Please return forms to:-**  **AJM Healthcare, Unit C5, Leyton Industrial Village, Argall Avenue, London, E10 7QP**  **Fax: 0808 196 1852 | referrals.walthamforest@ajmhealthcare.org** |

**Client Personal Details**

|  |  |
| --- | --- |
| Title: Mr  Mrs  Miss  Ms  Master | Other Title: |
| Family Name: | Address: |
| Given Name(s): |  |
| NHS Number : |  |
| Telephone Number:  Mobile Number: | Postcode: |
|  |
| Date of Birth: Ethnicity: | Email Address: |
| Preferred spoken language: Interpreter: Yes  No: |

Preferred Method of Contact

**Client Clinical Details**

|  |
| --- |
| Diagnoses/Prognosis: (include any other details or past medical history **which may be of use** to the referral eg, continence issues, mental health issues)    Allergies (if known): |

|  |  |
| --- | --- |
| Does the client have Mental Capacity: Yes  No  If the client **does not** have capacity please include contact details of the representative who will act in the best interests of the client | |
| Representative Name: | Telephone Number: |
| Address: |
|  | Email address (if known): |
| Postcode: | Relationship to Client: |

**GP Details Referrers Details (Details are required if the GP is not referrer)**

|  |  |
| --- | --- |
| Name of GP: | Name of Referrer: |
| GP Practice Address: | Job Role: |
|  | Address: |
| Postcode: | Telephone Number: |
| Telephone Number: | Email Address: |
| Email Address: | **(REFERRER MUST BE A QUALIFIED HEALTH PROFESSIONAL)** |
| Date completed: | Date completed: |

**PLEASE NOTE OUR PREFERRED CORRESPONDENCE IS BY EMAIL**

**Client Assessment**

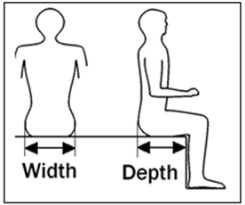
**Clinical details**

Height (Metres OR Feet & Inches): Weight (KG OR Stones & LBS):

(please state unit used) (please state unit used)

Hip Width (inches) (widest measurement across hips when client seated):

Upper Leg depth (inches) (from the back of the bottom to the back of the knee when client is seated):



**Tick the applicable description for each issue**

Walking ability: Unable  With equipment  Independent

Sitting balance: Needs support  No issues known

Method of Transfer: Hoist  With assistance  Independent

**Accommodation**

Does the client live alone? Yes  No

Does the client have a regular carer? Yes  No

(If yes, please give details below)

|  |  |
| --- | --- |
| Carer Name: | Relationship to Client: |
| Telephone number: | Mobile Number (if known): |
| What type of accommodation does the client live in? | |

Are there any known problems with the environment

that will affect the suitability of wheelchair equipment? Yes  No

(If yes please state in the space provided)

**Current Equipment**

Is the client already known to the Wheelchair Services NHS? Yes  No

**Equipment Required**

(You will need to complete the relevant sections for the equipment required)

Manual Chair  (complete Page 3**)**

Power Chair  (complete page 4. Powered chairs for outdoor only use are NOT supplied)

Child Buggy

Specialist Child Buggy / Specialist Seating

Pressure Relieving Cushion  (complete page 5)

**Signature of Referrer:**

**Manual Wheelchair (Complete only if you are requesting this item)**

**WILL BE SUPPLIED WITH STANDARD 2” CUSHION, UNLESS OTHERWISE STATED**

Manual Self Propel Required:  **OR** Manual Attendant-Propel Required:

(suitable for adults up to 21 stone) (suitable for adults up to 21 stone)



(weight of chair 38lbs / 18kg) (weight of chair 34 lbs / 15kg)

Standard “17x17” (width by depth):

Other seat size required (if different): Width: Depth:

How many days per week will the chair be used approximately/on average?

1 – 2 days

3 – 4 days

5 – 7 days

How long will the client be seated in the wheelchair for each day approximately/on average?

Less than 2 hours

2 – 4 hours

4 – 8 hours

8 hours +

What activity, if any, does the client need to carry out in the wheelchair?

(Tick all that apply) Mobility in the home

Work

Personal Care

Day Centre(s)

Outdoor Leisure

GP/Hospital Appointments

Education

Is a headrest required? Yes  No

(This is required if the client travels in the wheelchair whilst in a vehicle)

Is a specialised assessment required? Yes  No

(To be carried out by Wheelchair Occupational Therapist or Rehabilitation Engineer)

Other accessories required?

(Such as Stump Board, Leg Rest, Oxygen carrier etc…)

Please provide any other comments which may help with this referral including whether a Personal Wheelchair Budget is required?

(Please provide in the space below)

**Signature of Referrer:**

**Electric Indoor/Outdoor Power Chair (Complete only if you are requesting this item)**

**PLEASE NOTE A REQUEST CAN ONLY BE MADE FOR POWER IF THE CLIENT MEETS THE POWER CHAIR ELIGIBILITY CRITERIA.**

Electric Indoor Only Chair Required:  **OR** Electric Indoor/Outdoor Chair Required:

Can the client self-propel a manual wheelchair? Yes  No

Does the client have any visual impairment that would affect their ability to drive an Electric Wheelchair safely?

Yes  No

Does the client have any cognitive or visuo-spatial issues, or suffer from hearing impairment, epilepsy or other causes of loss of consciousness?

Yes  No

(If yes please provide details in the below space)

On which side do you require the hand control? Left  Right

Seat size of Electric Wheelchair required (width by depth): 15” x 16”

16” x 16”

17” x 17”

20” x 18”

Other seat size required (if different from above sizes): Width: Depth:

How many days per week would the wheelchair be used approximately/on average?

1 – 2 days

3 – 4 days

5 – 7 days

How long will the client be seated in the wheelchair for each day approximately/on average?

Less than 2 hours

2 – 8 hours

8 hours +

What activity, if any, does the client need to carry out in the wheelchair?

(Tick all that apply) Mobility in the home

Work

Personal Care

Day Centre(s)

Outdoor Leisure  GP/ Hospital Appointments

Education

Is a headrest required? (This is required if the client Yes  No

travels in the wheelchair whilst in a vehicle)

Please provide any other comments which may help with this referral?

(Please provide in the space below)

**Signature of Referrer:**

**Pressure relieving cushion (complete only if you are requesting this item)**

What is the primary need for the pressure relieving cushion?

Posture

Comfort

Pressure Relief

How long will the client be seated in the cushion for each day approximately/on average?

Less than 2 hours

2 – 8 hours

8 hours +

Does the client have the ability to push up on hands/arms to relieve pressure?

Yes  No  Don’t know

Does the client currently use a pressure relieving cushion?

Yes  No

If yes, please give name of cushion:

If applicable, please specify the exact cushion you are prescribing:

Width: Depth: Thickness:

**Pressure Sore History**

Current Waterlow Score: Date of score:

(Please include date of when this was measured)

What is the client’s pressure sore history?

No known history of pressure sores

Currently has a pressure sore

Where is/was the site of the pressure sore(s)?

(Tick all that apply) Left Trochanter

Right Trochanter

Natal Cleft

Other site (please state):

What is/was the grade of the pressure sore(s)?

Is a further assessment required? Yes  No

Please provide any additional comments to assist with the referral in the space below:

**Signature of Referrer:**

**Equality and Diversity Information**

Gender? Please select one only Male  Female

What is your ethnic group? Please select one box within a section

**White**

English/Welsh/Scottish/Northern Irish/British

Other British

Irish

Gypsy/ Irish Traveller

Any other White background

**Mixed**

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed background

**Asian or Asian British**

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background

**Black or Black British**

Caribbean

African

Any other Black background

**Other Ethnic Group**

Arab

Any other Ethnic Group

I do not want to answer this question

What is your religion? Please select one

No religion

Christian (all denominations)

Buddhist

Hindu

Jewish

Muslim

Sikh

Any other religion

I do not want to answer this question

What is your sexual orientation? If applicable, 18 years old and over

Bisexual

Gay

Heterosexual/Straight

Lesbian

Other

I do not want to answer this question