**London Central, North West Wheelchair Service**

**Mobility Posture Independence**



**Referral Form**

**Patient’s equal access form**

**Why we need you to complete this form**

We have a legal duty to ensure that patients accessing our services are treated fairly.

Please complete this form to help us comply with our duty.

*This form can be completed on paper or electronically, (check boxes can be clicked with the mouse ). Do not change the format or structure of this form, corrupted forms will be rejected.*

*Instructions how to send this form are at the end of the document.*

|  |  |
| --- | --- |
| **Personal Details:** | |
| Title: Mr / Mrs / Ms / Miss / Mstr / Other | Gender: |
| Surname: | First Name: |
| Date of Birth: | NHS No: |
| Home Address: | |
|  | Post Code: |
| Home telephone: | Mobile: |
| Preferred method of contact: | Email Address: |

|  |  |  |
| --- | --- | --- |
| GP Name: | Practice: | |
| Address: | | |
| Post Code: | Telephone No: | |
| Is the Service User under Continuing Healthcare? | Yes | No |
| Additional Information relating to Continuing Healthcare? | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Next of Kin: | | | Nominated Contact Person: | | | |
| Relationship: | | | Relationship: | | | |
| Telephone no: | | | Telephone no: | | | |
| **Power of Attorney:** | | | | | | |
| N/A | EPA | LPA (Finance/ Property) | | | LPA (Health/Welfare) | |
| Details: | | | | | | |
| **Children’s Referral Only:** | | | | | | |
| Primary Carer: | | | | | | |
| Person with Parental Responsibility: | | | | | | |
| Is this child subject to safeguarding plan? | | | | Yes | | No |

**A delay in the processing of your referral may occur if you do not complete all the sections on this page:**

|  |  |
| --- | --- |
| **Ethnicity**  Please indicate your ethnic background by ticking**🗹**. (or clicking ) one boxbelow This helps to identify earlier treatment for certain illness such as diabetes or high blood pressure, which may affect some patients more than others. | |
| **White**  British (English / Scottish / Welsh)  Irish  Other White Background  **Please specify**  **Mixed**  White and Black Caribbean  White and Black African  White and Asian  Other Mixed Background  **Please specify**  **Black or Black British**  Caribbean  African  OtherBlack Background.  **Please specify** | **Asian or Asian British**  Indian  Pakistani  Bangladeshi  Other Asian Background  **Please specify­­**  **Other Ethnic Groups**  Chinese  Any other ethnic group  **Please specify**  **Not stated**  **Not known**  **Declined to disclose (refused)** |

|  |  |  |
| --- | --- | --- |
| Do you speak English? | Yes | No |
| Do you need a qualified interpreter? | Yes | No |
| If yes, please indicate which language: | | |
| What is your preferred language? | | |

|  |  |
| --- | --- |
| Medical Conditions / diagnosis (including mental health): | |
| Medication: | |
| Height (estimate) | Weight (estimate) |
| Reason for referral / re-referral: | |

|  |  |  |
| --- | --- | --- |
| **All wheelchair and seating clinics are held at the Wheelchair Service premises.**  Limited resources are available to provide transport | | |
| Is the person medically unfit to travel? | Yes | No |
| If yes, explain why: | | |
| Is the person dependent on use of supplementary oxygen? | Yes | No |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Wheelchair Requirement** | | | | | | | | | | | | |
| **Does the person have a wheelchair?** | | | | | | | Yes | | | | | No |
| If yes, who supplied it? | | | | | | | | | | | | |
| **What type of wheelchair would you like to be assessed for?** | | | | | | | | | | | | |
|  | Self-propel (push by yourself) | | | | | | | | | | | |
|  | Attendant propelled (pushed by someone else) Please state by whom: | | | | | | | | | | | |
|  | Buggy (for children aged 30 months – 5 years) | | | | | | | | | | | |
|  | Power wheelchair (powered wheelchairs are not provided for outdoor use only) | | | | | | | | | | | |
| **Where will the wheelchair be used?** | | | | | | | Indoors | | | | Outdoors | |
| *(tick as many that apply)* | | | | | | | | | | | | |
| **How often will the wheelchair be used?** | | | | | | | | | | | | |
| 1 day a week or less | | | | Regularly throughout the week | | | | | | | | Daily |
| **Will the wheelchair be required for:** | | | | | Less than 6 months | | | | | More than 6 months | | |
| **How does the person move about** *(state aides used, number of people required, distance)* | | | | | | | | | | | | |
| Indoors:  Outdoors: | | | | | | | | | | | | |
| **How does the person get in and out of an arm chair?** | | | | | | | | | | | | |
| On own | | | With assistance of one | | | | | | With assistance of two | | | |
| Transfer board / rotor stand | | | Hoisted/unable | | | | | | Other: | | | |
| **Does the person have help at home?** | | | | | | | | | | | | |
|  | | Lives alone, independently | | | |  | | Lives alone, carer assistance | | | | |
|  | | Lives with family | | | |  | | Lives with family, plus carer assistance | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **This section is compulsory for Health Professionals to complete**  Non - professionals please complete to your best ability | | | | | | | | | | | | |
| Is the wheelchair essential for discharge? | | | | N/A | | | No | Yes Discharge date: | | | | |
| *(Essential for discharge is where provision will enable the person to be independent of carers)* | | | | | | | | | | | | |
| Is condition: | | Stable | | Deteriorating | | | | | | Rapidly deteriorating | | |
| Allergies:  No  Yes details: | | | | | | | | | | | | |
| Cognition: | | | | | | | | | | | | |
| Vision: | | | | | | | | | | | | |
| Surgery (past/planned): | | | | | | | | | | | | |
| History of falls: | | | | | | | | | | | | |
| Pressure area (grade/location): | | | | | | | | | | | | |
| Sitting balance: | | Independent | | Short periods | | | | | | With assistance of | | |
| **Posture:** | | | | | | | | | | | | |
| Pelvis: | Neutral | | Oblique | | Rotated | | | | Anterior Tilt | | | Posterior Tilt |
| Spine: | NAD | | Kyphosis | | Scoliosis | | | | Lordosis | | | Leaning |
| Trunk: | NAD | | High Tone | | Low Tone | | | | Variable | | | Fixed Deformities |
| U/Limbs: | NAD | | High Tone | | Low Tone | | | | Variable | | | Fixed Deformities |
| L/Limbs: | NAD | | High Tone | | Low Tone | | | | Variable | | | Fixed Deformities |
| Does this person have complex seating needs: | | | | | | | | | Yes | | | No |
|  | | | | | | | | | | | | |
| Does this person see any other health professionals? If so please provide contact details: | | | | | | | | | | | | |
| **Discipline** | | | | | | **Organisation** | | | | | **Contact Details** | |
| Consultant: | | | | | |  | | | | |  | |
| Occupational Therapy: | | | | | |  | | | | |  | |
| Physiotherapy: | | | | | |  | | | | |  | |
| Social Work: | | | | | |  | | | | |  | |
| Other: | | | | | |  | | | | |  | |
|  | | | | | | | | | | | | |
| Any other alerts (behaviour, substance use, MRSA, etc)? | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **Referrer details** | |
| The service user is aware this referral is being made | |
| I have completed this referral form truthfully and accurately | |
| If possible, I would like to be invited to the wheelchair and seating assessment | |
| Signed: (*not required for electronic submission by GP*)  Date: | |
| Name: | Relationship: |
|  | |
| Address | Post Code: |
| Phone | Fax: |
| Email: | |

***Please ensure all fields are completed. Referrals received with insufficient information will be returned and may lead to a delay in the referral being processed***

**Please note:**

1. This form can be completed by anyone wishing to refer to the Specialist Wheelchair Service
2. Date of referral received (for wait listing purposes) will only be sent when all essential information has been received
3. Equipment will only be provided for individuals who meet the eligibility criteria for provision
4. Referrals are waitlisted in accordance with the category of equipment required
5. It’s the responsibility of every user who sends a fax to ensure they are sending it to the correct number and we advise that you contact the service to ensure receipt of the referral. The service will not accept any liability if we have not received the referral

**If you have any queries completing this form please call 0808 164 2040**

|  |
| --- |
| **Please return this form to:**  **AJM Healthcare**  **Unit 3, Abbey Road Industrial Park**  **Commercial Way**  **Park Royal**  **London NW10 7XF**  **Tel: 0808 164 2040**  **Fax: 0808 133 0138**  **Email:** [**ajm.healthcare@nhs.net**](file:///C:\Users\nicole.denney\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\1WE4M8OO\ajm.healthcare@nhs.net)  \*Note if you are not sending from an NHS.net account, please use a secure encrypted email service such as Egress (www.egress.com). |