Oxford University Hospitals NHS
NHS Foundation Trust

Oxfordshire Wheelchair Service (OWS)
Oxford Centre for Enablement, Nuffield Orthopaedic Centre
WINDMILL ROAD, HEADINGTON, OXFORD OX3 7HE

REFERRAL FORM

PLEASE NOTE: Fields marked with an asterisk* are mandatory – forms <u>will be returned</u> if these fields are not completed

By completing this form you confirm that consent for the referral has been obtained from the patient

***Date of referral:** _____ ***Date of Birth:** _____

***Name**(in full)**:** _____ **Title:** _____

***Address:** _____ ***Tel No:** _____

* **Mob No:** _____

_____ ***Post Code:** _____

***NHS Number:**_____

***Next of kin:**_____**Tel**_____

***Special Delivery Instructions:** _____

Level of Priority: Urgent ☐ *Reason:

Required for discharge ☐ Standard ☐

Discharge Date (if relevant):

***Relevant Medical Details** (including drugs, any proposed action, e.g. surgery)**:**

***GP**(name & initial)**:** _____

***Address:** _____ ***Tel No:** _____

_____ ***Post Code:** _____

***Reason for Referral:**

***Physical Information:**

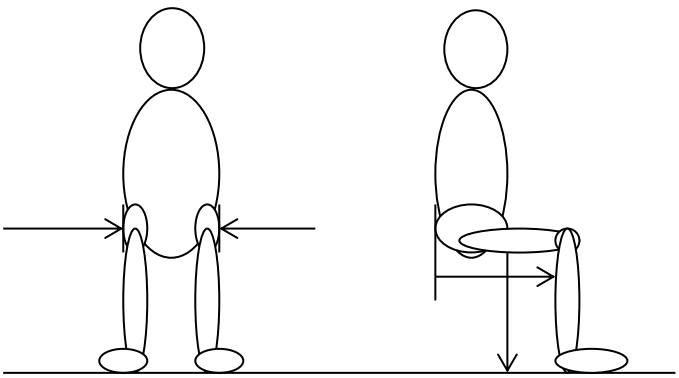
*Height: _____

*Weight: _____

Seat Width: _____

Seat depth: _____

Calf Length: _____



Level of Mobility (including any equipment used)**:**
Indoor:
Outdoor:

Transfer Method (including any equipment used)**:**

Are there any specific factors about the client's home (or other places where the wheelchair will be used) that should be taken into consideration? (*E.g. steps / narrow doorways)*

How often will the wheelchair be used?

Every day	☐	3 times a week or more	☐	Once a week or less	☐

For how long will the wheelchair be used at any one time?

More than 6 hours	☐	From 3 to 6 hours	☐	Less than 3 hour	☐

Where will the wheelchair be used most?

Indoors at home	☐	Outdoors only	☐	Indoors & outdoors	☐

How will the wheelchair be propelled?

By the user	☐	By an attendant	☐	Both	☐

Additional Information (e.g. fitness of attendant)**:**

Category of Need (please tick one box only):

Totally dependent upon a wheelchair for mobility due to permanent disability

Totally dependent upon a wheelchair for a limited period occurring within a long term disability

Non-dependent, but requires a wheelchair for daily use

Non-dependent, but requires a wheelchair for at least 1-3 days per week throughout the year

RECOMMENDATIONS

Provision of Equipment

If you are a OWS registered assessor and you wish to recommend suitable wheelchair and/or accessories please give as much relevant information as possible (e.g. wheelchair model, size, etc)

Wheelchair:

Accessories:

Pressure Distributing Cushion:
(Please note: these may only by requested for totally dependent users)

INFORMATION ON TISSUE VIABILITY
(This information is required only if you are requesting a pressure distributing cushion)

Does the client have an existing pressure ulcer? Yes: ☐ No: ☐

If yes, please give details of severity/grade and site of pressure ulcer(s):

Is the client at risk of developing a pressure ulcer? Yes: ☐ No: ☐

If yes, please give details of potential problems:

PRESSURE ULCER RISK ASSESSMENT – BRADEN SCALE **Patients with existing or previous pressure damage are immediately high risk**	
Sensory perception – *ability to respond meaningfully to pressure related discomfort* 1. Completely Limited 2. Very Limited 3. Slightly Limited 4. No impairment	**Mobility** – *ability to change and control body position* 1. Completely immobile 2. Very Limited 3. Slightly Limited 4. No limitations
Moisture – *degree to which skin is exposed to moisture* 1. Constantly moist 2. Very moist 3. Occasionally moist 4. Rarely moist	**Nutrition** – *Usual food intake* 1. Very poor 2. Probably inadequate 3. Adequate 4. Excellent
Activity – *degree of physical activity* 1. Bedfast 2. Chair fast 3. Walks Occasionally 4. Walks frequently	**Friction and Shear** 1. Problem 2. Potential problem 3. No apparent problem
	Total Score
	16+ = Low risk **13 – 15 = Medium risk** **Less than 12 = High risk**

To be used in conjunction with clinical judgement. Please note lower scores indicate a higher risk of pressure ulcer development.

Information on other Risk Factors (E.g. sitting posture, transfer technique etc)**:**

FURTHER ASSESSMENT

***Further assessment required?** Yes ☐ No ☐

If Yes, please tick one or more boxes:

☐ Non-powered wheelchair

☐ Powered wheelchair

☐ Postural Assessment

☐ Pressure distributing cushion

☐ Other (please specify)

Home visits will not be offered without a valid reason as to why this is required.
Please provide information below:

a) A brief rationale:

b) Access information:

Please indicate intended means of transport to appointment *(N.B: transport cannot be provided by OWS)***:**

***DETAILS OF REFERRER (to be filled in by person completing the form).**

Please note referrals for Nursing Home residents must be completed by a **GP/Occupational Therapist/Physiotherapist** OWS **does not** supply standard transit wheelchairs and associated equipment to Nursing Homes.

***Name:** _____

***Profession:** _____

***Contact Address:** _____

_____

***Telephone Number/email:** _____

***Availability:** _____

Registered Assessor Number: _____

***Signature:** _____ **Date:** _____

Please return completed form to OWS Administration, The Oxford Centre for Enablement, Nuffield Orthopaedic Centre Windmill Road, Headington, Oxford OX3 7HE, owsadministration@nhs.net (preferred route)