Oxfordshire Wheelchair Service

Referral Form

*Fields in italics are optional, but please provide us with as much information as you can to help us triage this referral.*

**Patient details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname |  | | *Title* | Mr Mrs Miss Ms Dr Mx |
| First name |  | | Date of birth |  |
| Address |  | | NHS number |  |
| Telephone no |  |
| *Mobile no* |  |
| Postcode |  | | *Email* |  |
| If care home resident, what status is patient? | | nursing residential | | |
| Does the patient present a risk to a lone worker? | | no yes (give details) | | |

**Priority**

|  |  |  |  |
| --- | --- | --- | --- |
| Level of priority | routine urgent | | |
| If urgent, reason | required for discharge palliative pressure sores health & safety risk | | |
| Details: | | |
| If required for discharge | Date of discharge |  | estimated confirmed |
| Delivery location for discharge (ward & hospital) |  | Phone/bleep for arranging delivery |  |
| Any delivery instructions or access issues? | |  | |

**Reason for referral**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| New assessment for: | self-propelled attendant powered buggy posture pressure | | | | |
| Review due to: | growth discomfort/pain deterioration pressure sores other | | | | |
| *Additional information* |  | | | | |
| *Does patient currently have a wheelchair?* | | no yes – from OWS yes – other NHS  yes – private  yes - unknown | | | |
| *What wheelchair do they have?* | | self-propelled manual attendant manual powered not known | | | |
| Where will the wheelchair be used? | | | outdoors only | indoors at home | indoors & outdoors |
| How often will the wheelchair be used? | | | every day | at least 3 times per week | less than 3 times per week |
| How long per day will the wheelchair be used? | | | up to 3 hours | 3-6 hours | more than 6 hours |
| Who will push the wheelchair? | | | attendant | user | both |
| Further assessment required? | | no  yes | | | |
| Home visit required? | | no  yes – no safe wheelchair to travel in yes – other (specify) | | | |
| *Equipment requested (if known)* | |  | | | |

**Notes re eligibility:**

* If the patient only needs the wheelchair outdoors, they are eligible for a standard steel wheelchair only
* Powered chairs can only be issued to patients who need to use them indoors (cannot functionally walk or self-propel a manual wheelchair) and are able to drive the chair safely themselves
* Standard transit wheelchairs are not supplied to nursing home residents

|  |
| --- |
| **Seat width (SW):** measure at the widest part of the hip, ensure the tape measure does not bend |
| **Seat depth (SD):** from the back of the knees to the rear most part of the bottom |
| **Calf length (CL):** from the back of the knee to the floor/under the heel |

**SW**

**CL**

**SD**

**Physical & functional information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Height |  | | | metresfeet/inches | *Seat width* |  | *cminches* |
| Weight |  | | | kg stone/pounds | *Seat depth* |  | *cminches* |
| Height/weight | | estimated measured | | | *Calf length* |  | *cminches* |
| Able to self-propel? | | yes no | | | **See diagram above for how to measure these** | | |
| Walking ability | Indoors | | independent with assistance/aids unable to walk | | | | |
| Outdoors | | independent with assistance/aids unable to walk | | | | |
| Mobility status | | | deteriorating stable improving | | | | |
| Transfer method | | | independent with assistance with aids hoist | | | | |
| Sitting balance | | | able to sit unaided needs support | | | | |
| *Postural issues (if known)* | | | scoliosis kyphosis hip/knee limitations (give details) | | | | |

**Medical details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diagnosis/es | stroke cerebral palsy spinal cord injury Parkinson’s diabetes muscular dystrophy  MND brain injury multiple sclerosis dementia amputation (specify side & level) | | | | |
| other (please specify) |  | | | |
| Does the patient have learning disabilities? | | | yes no | | |
| Does the patient currently have a pressure sore? | | | yes no | | |
| If yes, state location and grade | | |  | | |
| Is the patient at high risk of pressure sores? | | | yes no | | |
| If yes, give risk factors | | |  | | |
| Doe the patient have epilepsy or seizures? | | | yes no | Details |  |

**Next of kin details**

|  |  |  |  |
| --- | --- | --- | --- |
| *Name* |  | *Relationship to patient* |  |
| *Phone no* |  | *Email* |  |

**GP details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Practice name |  |
| Address |  | Telephone no |  |

**Referrer details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Email |  |
| Profession |  | Telephone no |  |
| Availability |  | Bleep |  |
| Address |  | Date of referral |  |

Please return this form to owsadministration@nhs.net