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 |  | [ ] metres[ ] feet/inches | *Seat width* |  | [ ] *cm*[ ] *inches* |
| Weight |  | [ ] kg [ ] stone/pounds | *Seat depth* |  | [ ] *cm*[ ] *inches* |
| Height/weight | [ ] estimated [ ] measured | *Calf length* |  | [ ] *cm*[ ] *inches* |
| 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