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| SPECIALIST DISABILITY SERVICEREFERRAL FORM |
| Oxford Centre for Enablement, Windmill Road, Headington, Oxford, OX3 7HET: 01865 227 447 | specialist.disabilityservice@nhs.net |
| **CLIENT’S DETAILS** |
| Full name: |  | Title: |  |
| Address: |  | Date of birth: |  |
| NHS no: |  |
| Contact for arranging appointment: | Telephone no: |  |
| Mobile no: |  |
| Email: |  |
| Diagnoses: |  | Height: |  |
|  |  | Weight: |  |
| Other relevant medical details (e.g. planned surgery, tissue status): |  |
| Consent gained from the client for this referral: | Yes [ ]  | No [ ]  | Best interest [ ]  |
| GP (name and initial)\*: |  |
| Name/place of practice: |  |
| *\* Essential information to identify if client is in an area supported by Specialist Disability Service* |
| **REFERRER’S DETAILS** |
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| Referred by: |  | Job title: |  |
| Address: |  | Email: |  |
| Mobile: |  |
| Office: |  |

**OTHER RELEVANT PROFESSIONALS INVOLVED** (as applicable) |
| Name and profession | Contact detail | Involvement |
|  |  |  |
|  |  |  |
|  |  |  |
| Indicate means of transport to appointment: | Own/home vehicle |  |  Ambulance |  |
| If a home visit is required, please provide: | A brief rationale |  |
| Access details |  |
| **REASON FOR REFERRAL** |
| Please select the area(s) of the service for which a referral is being made:*N.B. Please complete a different referral from for Mobile Arm Support, Communication aid and Voice amplifier, or Environmental Controls and Computer Access:**https://www.ouh.nhs.uk/oce/referrals/specialist-disability-services.aspx*  |
| Wheelchair seating (not Oxfordshire): |  | Mounting of electronic assistive technology devices: |  |
| Static seating: |  | Baby care advice for people with physical disability: |  |
| Bespoke/modification for toilet seat / shower chair: |  | Complex wheelchair controls: |  |
| Bed positioning: |  |  |  |
| Detailed reason for referral, including aims of intervention *(please provide sufficient information to allow appropriate prioritisation):* |  |
| Other relevant information: |  |
| Details of home/day care arrangements: |  |
| Level of mobility: (include type of equipment used) | Indoors: |  |
| Outdoors: |  |
| Method of transfer:Equipment used |  |
| Care needs: |  |
| Ability to communicate and method of communication: |  |
| Signed: |  | Date of referral: |  |
| *Document name* | *SDS referral form* | *Issue Date/ Author* | *05/2014 DL* | *Reviewed* | *14/03/2024 RL* | *Version* | *2.0* |

Please return completed form to Specialist Disability Service, The Oxford Centre for Enablement, Nuffield Orthopaedic Centre Windmill Road, Headington, Oxford OX3 7HE, specialist.disabilityservice@nhs.net (preferred route).