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| SPECIALIST DISABILITY SERVICEREFERRAL FORM | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oxford Centre for Enablement, Windmill Road, Headington, Oxford, OX3 7HE  T: 01865 227 447 | [specialist.disabilityservice@nhs.net](mailto: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** | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | Referred by: |  | Job title: |  | | Address: |  | Email: |  | | Mobile: |  | | Office: |  |   **OTHER RELEVANT PROFESSIONALS INVOLVED** (as applicable) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name and profession | | | | | | | Contact detail | | | | | | | | | | | | | Involvement | | | | | |
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| 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](mailto:specialist.disabilityservice@nhs.net) (preferred route).