Northamptonshire Wheelchair Service - GP Referral Form

Important Recommendations

- Do not complete from an internet browser due to incompatibilities, (right click and save file to secure location).
- Use the latest Adobe Acrobat DC Reader.
- **Use the submit button at the bottom of this form to send the data to the service.**
- Dates must be keyed in full DD/MM/YYYY format.
- Signature is not mandatory at this stage but may be required in the future, register for a Digital Signature.
- Please complete all sections fully. Incomplete forms will be returned to the referrer.
- We do not provide wheelchairs to ANY care homes for portering purposes; this is the responsibility of the care home.
- Enquiries to cabsl.northamptonshirewheelchairservice@nhs.net Tel **01536 511025**

Service User Details		GP Details	
NHS Number		GP Name	
Title		Nat GP Code	
Forename(s)		Postcode	
Surname		Tel No.	
Date of Birth	(DD/MM/YYYY)	Date	

Gender							
House Name							
Address 1							
Address 2							
Town							
County							
Postcode							
Email Address							
Telephone No			Mobile No				
Preferred method of communication	Phone		Email		E-Consultation		
Ethnicity							
Main Language							
Religion							
Disability / Condition							
Relevant Medical Details							
Critical Case	Yes		No				

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Physical Measurements

Height	Feet	Inches	Metres
Weight	Stone	Lbs	Kilos
Hip Width		Inches	cm
Please measure in a straight line across the pelvis			
Is this person already in possession of an NHS wheelchair?		Yes		No	

Postural Needs

Has this person any postural needs we need to be aware of?	Yes		No	
If yes, please specify				

Requirements

Does the person have limited walking ability likely to last in excess of six months?			Yes		No	
How often will the wheelchair be used?						
Type required. Manual Self Propelling/ Attendant Operated/Powered Wheelchair						
Is the wheelchair required for	Indoor		Outdoor		Both	

Please note that we do not provide scooters, powered chairs for outdoor use only or attendant operated powered wheelchairs.

Accessories

Any accessories required?	

Cushion

Is a standard foam cushion adequate	Yes		No	
Will the patient be using the wheelchair for more than 4 hours at a time?	Yes		No	
Does this person have any pressure ulcers at present?	Yes		No	
If yes, please state site and category of ulcer				

Continence Status

Please state continence status	
Waterlow Score	
Additional Information	

If a powered wheelchair is requested please fill in the section on the following page as we require additional information to ensure the safety of both service user and other pedestrians when the powered wheelchair is in use.

For Powered Wheelchairs Only; please complete this section

Medical Questionnaire Section				
This is needed before an assessment can be arranged for a powered wheelchair for your patient. Please tick the selected answer.				
1. Mobility In your opinion, is this person unable to walk or self-propel a manual wheelchair, or are they medically at risk to do so? Add any comments below	Yes		No	
2. Is this patient affected by the following:				
A. Epilepsy/blackouts	Yes		No	
Has the patient had a seizure in the past year?	Yes		No	
B. Any medication or their side effects Add any comments below	Yes		No	
C. Visual impairments, please give details below	Yes		No	
D. Mental health problems (relevant to safe wheelchair use) with comments	Yes		No	
E. Challenging Behaviour may affect safe use of a powered wheelchair	Yes		No	
F. Perceptual deficits e.g. hemianopia	Yes		No	
G. Any other conditions that may affect safe use of a powered chair?	Yes		No	
3. In my opinion, this individual is medically fit to control a powered wheelchair?	Yes		No	

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