

Derbyshire Wheelchair Service – GP Referral Form

MANUAL AND POWERED WHEELCHAIRS.

The patient must have a permanent physical impairment or medical condition that affects their ability to walk and will need a wheelchair for more than 6 months.

We do not provide wheelchairs to care homes for portering purposes, this is the responsibility of the care home.

For powered wheelchairs, please complete the medical questionnaire at the end of this referral form. Please note we do not supply outdoor powered wheelchairs only. The medical questionnaire is NOT required for manual wheelchair referrals.

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.
- This form should be completed by the Service User's Healthcare Professional for wheelchairs or buggy requests.
- Enquiries to cabsl.derbyshirewheelchairservice@nhs.net

Patient Information *essential information*				GP details									
NHS No *				GP Name*									
Title *				GP Code									
First Name *				GP Address*									
Surname *				GP Phone No.									
Address*													
Town													
County													
Postcode *													
Date of Birth *				Email									
Phone No. *				Mobile No.									
Preferred method of communication				Phone			Text			Email			
Gender*	Male			Female			Other			Prefer to be described as			
Ethnicity *							Main Language*						
Religion							Interpreter Required*		Yes			No	

RELEVANT MEDICAL DETAILS *

Critical case (e.g. end of life care)	Yes		No	
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USAGE : How often will the wheelchair be used *							
Occasional use	<input type="checkbox"/>	1 – 2 times a week	<input type="checkbox"/>				
3 times a week or more	<input type="checkbox"/>	Daily	<input type="checkbox"/>				
Other	<input type="checkbox"/>	Please state					
Where will the wheelchair be used *		Indoors	<input type="checkbox"/>	Outdoors	<input type="checkbox"/>	Indoors and outdoors	<input type="checkbox"/>
Does the patient already have an NHS wheelchair *		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unsure	<input type="checkbox"/>
What type of wheelchair do you require*		Transit	<input type="checkbox"/>	Self-Propel	<input type="checkbox"/>		
		Buggy	<input type="checkbox"/>	Powered Wheelchair	<input type="checkbox"/>		
MEASUREMENTS							
Height*		Feet	<input type="text"/>	Inches	<input type="text"/>	Metres	<input type="text"/>
Weight*		Stone	<input type="text"/>	Lbs	<input type="text"/>	Kilos	<input type="text"/>
POSTURE							
Can the person maintain sitting balance in a wheelchair				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Any postural concerns to be aware of				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments							
ASSESSMENT DETAILS CUSHION							
Is a standard foam cushion adequate *				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
TISSUE VIABILITY							
Pressure ulcers				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Pressure ulcer Location		<input type="text"/>		Pressure ulcer Category		<input type="text"/>	
Pressure ulcer Detail		<input type="text"/>					
PERSONAL WHEELCHAIR BUDGET (PWB)							
Is the patient interested in PWB				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
would like more information				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Any additional information you would like us to know		<input type="text"/>					
Privacy and Data Storage Consent							
<p>The information you provide in this form is used solely for processing your enquiry and will not be used for any other purpose. Blatchford do not store any backups of the information provided and any information you submit is sent directly to the NHS. For more information, please see our Privacy Policy.</p> <p>GDPR Consent *</p>							
<input type="checkbox"/> I acknowledge that any personal data submitted by me will be processed in accordance with Blatchford's Privacy Policy							

MEDICAL QUESTIONNAIRE – POWERED WHEELCHAIRS ONLY

****TO BE COMPLETED BY A DOCTOR ONLY****

Please complete the request for medical information. This is required before an assessment can be arranged for a powered wheelchair.

Please tick the selected answer *PLEASE NOTE ALL QUESTIONS MUST BE ANSWERED*				
1. MOBILITY				
Is the patient unable to walk or self-propel a manual wheelchair / or at medical risk to do so	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments				
2. Is the patient affected by any of the following				
a) Epilepsy / blackouts	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments				
b) Seizures in the past year	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments				
c) Any medication or their side effects	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments				
d) Visual impairments	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments				
e) Mental health problems (relevant to safe wheelchair use)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments				
f) Perceptual deficits e.g. neglect	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments				
g) Any other conditions that may affect safe use of a powered chair	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comments				
3. In my opinion, this individual is <u>medically fit</u> to control a powered wheelchair				
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	<input type="checkbox"/>
Additional comments				
Name of doctor completing *				
National GP Code				
Date (DD/MM/YYYY)				

Following submission of your referral you will receive an email acknowledgement.
 If you do not receive confirmation OR if you are unable to SUBMIT this referral, please save the referral as a pdf and attach and send to cabsl.derbyshirewheelchairservice@nhs.net