Wheelchair Referral Form CONFIDENTIAL

Instructions

- This form should be used when a client requires a wheelchair because of a permanent illness or disability (Permanent is defined as 6 months or more).
- **This form should ONLY be completed by clients GP or another health care professional who has completed the Wheelchair Service accredited referrer course.** (For information on how to become an accredited referrer, please contact the wheelchair service)
- **Sections must be completed where specified. Incomplete, unsigned and/or undated referral forms will be returned.**
- Further information, referral forms and criteria for issue can be found on our website:

www.nbt.nhs.uk/bristol-centre-enablement

North Bristol NHS
NHS Trust

Bristol Centre for Enablement
Wheelchair & Special Seating Services
Highwood Pavilions
Jupiter Road
Patchway, Bristol
BS34 5BW
Tel: 0117 414 4900
Fax: 0117 340 3454

Client Details (This section must be fully completed)

Surname | **NHS Number**

Title | **Forenames**

Address | **Telephone (Home)** | **Telephone (Work/Mobile)**

Post Code

Email address: | **Ethnic Origin**

Address Type : **Private Address** | **Nursing Home** | **Residential Home**

Date of Birth / / | **Height** | **Weight**

Accurate weight information is essential for prescription of a wheelchair with suitable weight limit

Referrer Details & GP Details (This section must be fully completed)

Referrer | **Profession**

Address | **Telephone** | **Fax**

Post Code

Email address:

General Practitioner

Practice | **Telephone** | **Fax**

Post Code

BCE Staff Use Only :

BDSC Number Allocated :

Date:

Received Stamp :

Medical History (Diagnosis and Fitness to Self Propel must be completed)

Diagnosis (Please Print Clearly)

Is client medically fit to self propel a wheelchair?	**YES** ☐	**NO** ☐	**Short Supervised Distances Only** ☐	
Infection Risk :	**YES** ☐	**NO** ☐	If YES, Please Specify above in diagnosis	
In-Patient :	**YES** ☐	**NO** ☐	If YES, Please give details below	

Is a Wheelchair required for Discharge? (If yes, include discharge date and destination.)

Functional Ability:

Left Upper Limb	**Right Upper Limb**
Left Lower Limb	**Right Lower Limb**
Vision	

Walking Ability : **None** ☐ **Indoors Only** ☐ **Short Distances Outdoors** ☐

Walking Aids / Prothesis / Orthosis in use:

Postural Information: (Pelvic Orientation / Spinal Deformity etc)

Sitting Balance / Ability

Pain

Tone/Spasm/Tremor

Weight Trend : **Stable** ☐ **Increasing** ☐ **Decreasing** ☐

Wheelchair Use (This section must be fully completed)

Term of Use :	**Less than 6 months** ☐	**More than 6 months** ☐					
Days use per week :	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	**6** ☐	**7** ☐
Period sat in wheelchair (on average):	**Less than 2 hours** ☐	**2 to 8 hours** ☐	**More than 8 hours** ☐				
Type of Use :	**Indoors Only** ☐	**Outdoors Only** ☐	**Indoors and outdoors** ☐				

Carer Details

This section must be completed for transit (attendant pushed) wheelchairs

Named Carer		Relationship	

Address	Telephone
	Post Code

Relevant Carer needs:

Social and Environment

Please give details of any factors that need to be considered:

Size constraints (e.g. narrow doors)

Other Healthcare Professionals involved (Consultant, PT, OT, Prosthetist, Orthotist, District Nurse, Health visitor, etc)

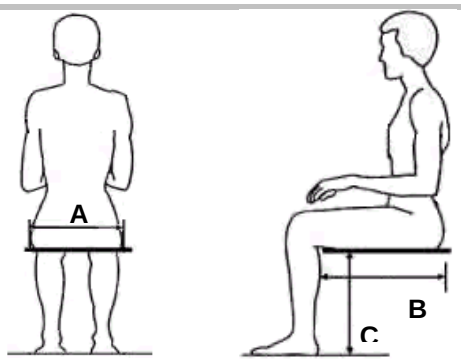
Please give names and contact numbers :

Other organisations involved (Day centre, school, workplace, nursery etc.)

Will client be travelling on transport while seated in wheelchair / buggy? **YES** ☐ **NO** ☐

Physical Measurements In Sitting

(This section must be fully completed)



	Measurement	Units
A) Hip Width		Inch/cm
B) Rear of buttock to back of knee		Inch/cm
C) Back of knee to base of foot		Inch/cm

Other Details

Please continue on separate sheet if needed

Wheelchair Requirements (Option 1,2 or 3 must be completed)

1 **Prescribe Manual Wheelchair/Buggy** ☐ **The client will be sent the wheelchair you prescribe.**

Adult Self Propel	Adult Transit	Paediatric Self Propel	Paediatric Transit	Major Buggy One Size Only
 ☐	 ☐	 ☐	 ☐	 ☐

Adult chair sizes

Please tick size prescribing:
Sizes in cm (inches)

38 x 40.5 (15” x 16”) ☐	43 x 43 (17” x 17”) ☐
40.5 x 40.5 (16” x 16”) ☐	46 x 43 (18” x 17”) ☐

Paediatric chair sizes

A wide range of seat widths and depths are available. Please ensure you complete the physical measurements on page 3. Our assessment staff will then allocate the appropriate size of wheelchair.

Accessories required:		Reasoning	

2 **Further Assessment for Manual Wheelchair/Buggy?** ☐ Client will be placed on waiting list for assessment at BCE

3 **Further Assessment for Electrically Powered Indoor Wheelchair** ☐ Client will be placed on waiting list for a home assessment

Electrically Powered Indoor/Outdoor Wheelchair Please submit requests using the Indoor/Outdoor Wheelchair Referral Form.

Cushion A 50mm (2") foam cushion is supplied as standard with every wheelchair. For alternative cushions, please submit a Wheelchair Cushion Referral form to the Wheelchair Service.

Wheelchair Voucher: The NHS wheelchair voucher scheme has been introduced to give wheelchair users greater freedom to select their wheelchair. A person who qualifies for an NHS wheelchair may have a voucher as part payment for a wheelchair of their choice. Usually vouchers can only be issued following assessment at the wheelchair centre. Further information is available in leaflet form or on our website. Tick this box if the client would like us to send them a leaflet: ☐

Delivery address if different from clients address:

Address:	**Telephone:** **Post Code:**

Replacement required for hospital stock : Please attach Stock Request Form.	**YES** ☐	**NO** ☐	**Serial Number of wheelchair issued:**	

Referrers Signature (This section must be fully completed)

I, the referrer, confirm that the information supplied with this form is correct to the best of my knowledge and that the client this referral concerns is aware of and agrees with the content of this form.

Referrers Signature		**Date**		**Accreditation Number**				

Thank you for completing this form