**Bristol Communication Aid Service / Dame Hannah Rogers Trust Expectations**

**Mounting Referral Form**

**Referral** – Please complete this form if you wish to make a **referral for mounting only**. For example, to request a wheelchair mount for a device or provision of an additional mounting system e.g. floor mount or desk mount. This form can also be used for making a **re-referral for mounting** e.g if someone’s wheelchair or school chair has changed, or existing mounting needs adjustment or repair.

**Please note:**

* Wheelchair mounting appointments will take place at the Bristol Centre for Enablement unless there are exceptional circumstances.
* A maximum of 2 wheelchair mounting systems will be provided (e.g. manual and powered wheelchair, manual and classroom chair) in addition to another mounting system e.g. floor mount or desk mount
* Where a child has identical dynamic seats at home and at school, a single mounting system will be provided which can be used in both environments.

# Bristol Communication Aid Service / Dame Hannah Rogers Trust Mounting Referral Form

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| **Name:**  **Address** (inc postcode)**:** |
| **Telephone:** |
| **Email:** |
| **Clinical Commissioning:** |

**Client Details**

**Referring Professional’s Details**

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| **Name:**  **Date of Birth:**  **Address** (inc postcode)**:**  **5** |
| **Telephone:** |
| **Email:** |
| **NHS number:**  **(mandatory)** |
| **Next of Kin name:**  **Relationship:** |
| **Address(es): (if different from above)**    **Telephone:** |

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| **School/Pre-school:** |
| **Address:** |
| **Telephone:** |

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| **GP name and address:**  **(mandatory)** | | **For Adult referrals only:**  **Does the person require hospital**  **transport?**  **Will an escort be accompanying the person?**  **Yes  No** | | |
| **Is the person able to travel to their local AAC centre (BCAS/DHRT)?***(NB, home/school visits will only be considered in exceptional circumstances)* **Yes  No** | |
| **Days available for appointments:**  (referrer & client) | | **Make and model of wheelchair used for travel if appropriate:** | | |
| **Is this a new or existing mounting referral** (please tick) **New  Existing** | | | | |
| **Time since last BCAS input** (please tick) | | | | |
| **<6 months** | **6mth >12mths** | | **1yr>2yrs** | **>2yrs** |
| **Date last seen by BCAS/DHRT :** | | | | |

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| **Reason for mounting referral:** *(please give brief summary & provide further details on the next page)* |

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| **High Tech AAC:** What AAC device is the client currently using?  *Please note any issues or difficulties in each area.*  Device:  Access method:  Software and/or vocabulary package: |
| **Client’s Condition:** Has the client’s condition or diagnosis changed or deteriorated? Yes/No  If yes, please give details. Please include information regarding hand function, posture and head control: |
| **Mounting:** Does the client have a mounting system provided by BCAS? Yes/No  Please give details of the wheelchair/dynamic seating which mounting is required for?  If client has a powered chair, is the person driving independently? Yes/No  If No, please detail any restrictions:  Who owns the wheelchair/dynamic seat? (Please give details and include telephone number) |
| Is a mounting solution required for any other situation e.g:   * For use in bed? Yes/No * For use in an armchair? Yes/No * Other – please give details |

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_