**AAC WEST Specialist Service Bristol/Plymouth 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.

**Please complete all sections of this form as fully as possible. We are aware that this form is long, however, detail here saves time in triage and later appointments.**

| **Patient Details** | **Referrer Details** |
| --- | --- |
| Name: Date of Birth: Address (including postcode):  | Name:Address (including postcode): |
| Telephone: | Telephone: |
| Email: | Email: |
| NHS number: | Relationship to patient: |
| **Next of kin name**: | **School/Pre-school (if applicable):** |
| Address(es): (if different from above)  | Address: |
| Telephone: | Telephone: |
| Email: | Email: |

Days available for appointments (Please tick the relevant boxes)

| Referrer | Monday [ ]  | Tuesday [ ]  | Wednesday [ ]  | Thursday [ ]  | Friday [ ]  |
| --- | --- | --- | --- | --- | --- |
| Patient | Monday [ ]  | Tuesday [ ]  | Wednesday [ ]  | Thursday [ ]  | Friday [ ]  |

|  |  |
| --- | --- |
| Is the patient able to travel to their local AAC centre (Bristol or Plymouth)? | Yes [ ]  No[ ]  |

| **Ethnicity code** *(please ask the patient to indicate which code best matches their heritage/identity. See list at the end of this form)* | Code (A-Z):  |
| --- | --- |
| **Language:** Is the patient’s home language English? | Yes [ ]  No[ ]  |
| If no, what languages are spoken at home? *(Please add relevant details)* |  |
| Does the patient or family require an interpreter? | Yes [ ]  No[ ]  |
| If yes, what language? |  |

**Other professionals involved relevant to referral (please include GP, Paediatrician, OT, Physio, Advisory Teachers). Please ensure consent is gained for sharing information with these professionals (see consent section).**

**PLEASE NOTE: REFERRALS CANNOT BE ACCEPTED WITHOUT GP DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Professional | Address | Tel Number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

| **Is this a new or existing mounting referral** (please tick) **New** [ ] **Existing** [ ]  |
| --- |
| **Time since last AAC WEST input** (please tick) |

| **<6 months** [ ]  | **6mth >12mths** [ ]  | **1yr>2yrs** [ ]  | **>2yrs** [ ]  |
| --- | --- | --- | --- |

| **Date last seen by Bristol/Plymouth :** |
| --- |

|  |
| --- |
| **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? If yes, please give details: Please include information regarding hand function, posture and head control: | Yes [ ]  No [ ]  |
| **Mounting:** Does the client have a mounting system provided by AAC WEST? If client has a powered chair, is the person driving independently? If No, please detail any restrictions:  | Yes [ ]  No [ ] Yes [ ]  No[ ]  |
| **PLEASE NOTE: REFFERALS CANNOT BE ACCEPTED WITHOUT DETAILS OF SEATING SYSTEMS.**Which wheelchair/dynamic seating system is mounting required for?Chair make [REQUIRED]:Model [REQUIRED]:Who owns the wheelchair/dynamic seat? Owner [REQUIRED]:Telephone number [REQUIRED]:Patient’s weight: *Please include picture of the seating systems.* |  |
| Is a mounting solution required for any other situation e.g:* For use in bed?
* For use in an armchair?
* Other (please give details):
 | Yes [ ]  No[ ] Yes [ ]  No[ ] Yes [ ]  No[ ]  |

**PLEASE NOTE: REFERRALS CANNOT BE ACCEPTED UNLESS THE CONSENT SECTION BELOW IS COMPLETED IN FULL**

|  |  |
| --- | --- |
| **Consent to the referral:** Can the patient consent to the referral?*N.B. if unclear whether a patient is able to consent to this referral, a capacity assessment should be undertaken written/visual supports appropriate to the patient’s needs.*  | Yes [ ]  No [ ]  |
| If **YES** has the patient consented to this referral?*Please detail how the patient gave their consent (verbally, using AAC, gesture etc.)*  | Yes [ ]  No [ ] How consented: |
| If **NO and patient 16 or over** - has the referral be discussed with relevant parties and agreed to be in the patient’s best interest?Discussed with/name:Relationship to patient:Reason consent not gained from patient: | Yes [ ]  No [ ] N/A [ ]   |
| If **NO and patient under 16** - has someone consented on behalf of the patient? Name:Relationship to patient:Reason consent not gained from patient: | Yes [ ]  No [ ] N/A [ ]   |
| **Consent to emailing:** Does the patient/their NOK if patient is under 16, consent to be contacted by email?*Please be aware that confidentiality cannot be guaranteed, and the NHS is not liable for the confidentiality or security of any message once it’s been sent*. | Yes [ ]  No [ ]  |
| **Consent to information sharing:** Can the patient consent to information sharing?*Examples of symbols to support this conversation can be downloaded at* [*https://www.nbt.nhs.uk/bristol-centre-enablement/referral-centre/aac-west-referral*](https://www.nbt.nhs.uk/bristol-centre-enablement/referral-centre/aac-west-referral) | Yes [ ]  No [ ] (see below) |
| [ ]  If **YES**, discuss information sharing consent with patient and indicate decisions below.[ ]  If **NO and patient 16 or over** - discuss information sharing consent with relevant parties/individuals and indicate best interest decisions below.**Discussed with**:[ ]  If **NO and patient under 16** - discuss information sharing consent with parent/guardian and indicate decisions below.**Discussed with**:  |  |
| *Please indicate who AAC WEST can share information with (as per patient’s consent, parental consent or best interests decision) and provide contact details on page 3 in “Other professionals involved relevant to referral” section.*[ ]  Other members of AAC WEST team (SLT, OT, Teacher, Assistant, Clinical Technologist, technical team, admin team)[ ]  GP [ ]  Local SLT [ ]  School staff (if relevant)[ ]  Carers / Support Workers [ ]  Day centre staff [ ]  Occupational Therapist [ ]  Physiotherapist[ ]  Advisory Teachers, e.g. Qualified Teacher of VI or HI.[ ]  Wheelchair service (needed for mounting)[ ]  Environmental Controls[ ]  Other: [ ]  Other AAC Specialised Service (if patient moves out of the South West)[ ]  Family/friends (specify who and provide contact details):[ ]  DON’T SHARE INFO WITH:  |  |

Signed:

Name:

Date of Completion:

**Ethnicity code:**

|  |  |  |  |
| --- | --- | --- | --- |
| A | White – British  | K | Asian or Asian British – Bangladeshi |
| B | White – Irish  | L | Asian or Asian British - any other Asian background |
| C | White – Any other white background | M | Black or Black British – Caribbean |
| D | Mixed – White and Black Caribbean | N | Black or Black British – African |
| E | Mixed – White and Black African | P | Black or Black British – Any other Black background |
| F | Mixed – White and Asian | R | Chinese |
| G | Mixed – Any other mixed background | S | Any other ethnic group |
| H | Asian or Asian British – Indian  | Z | Does not wish to disclose |
| J | Asian or Asian British – Paskistani |  |  |