**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)* |

|  |
| --- |
| **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 |  |  |