**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** | **Referring SLT Details** |
| --- | --- |
| Name:  Date of Birth:  Address (including postcode): | Name:  Address (including postcode): |
| Telephone: | Telephone: |
| Email: | Email: |
| NHS number: | Details of SLT employment: (school, NHS trust etc.)  *Please note referrals can only be accepted from SLTs employed by a statutory body e.g. NHS, School, Local Authority.* |
| **Next of kin name**: | **School/Pre-school:** |
| Address(es): (if different from above) | Address: |
| Telephone: | Telephone: |
| Email: | Email: |

Days available for appointments:

| SLT | Monday | Tuesday | Wednesday | Thursday | Friday |
| --- | --- | --- | --- | --- | --- |
| Patient | Monday | Tuesday | Wednesday | Thursday | Friday |

| Is the patient’s first language English? | Yes  No |
| --- | --- |
| Do the family require an interpreter? | Yes  No |

| If yes, what language? |
| --- |

| Is the patient able to travel to their local AAC centre (Bristol or Plymouth Base)? |
| --- |

**Other professionals involved relevant to referral (please include GP, Paediatrician, OT, Physio, Advisory Teachers):**

**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? 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 AAC WEST? 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_