

Highland Wheelchair & Seating Services

**Dept of Medical Physics and Bioengineering**

**Raigmore Hospital, INVERNESS, IV2 3UJ
Tel No: 01463 704167 Fax No 01463 705717**

**WHEELCHAIR REFERRAL FORM**

PLEASE COMPLETE IN BLOCK CAPITALS, AND EMAIL TO: NHSH.WHEELCHAIRREFERRAL@NHS.SCOT

FOR INFORMATION ON HOW TO CORRECTLY COMPLETE THIS REFERRAL PLEASE REFER TO GUIDELINES ON REVERSE.

Please indicate whether this referral is a new referral or an existing wheelchair user

New [ ]  Existing [ ]  If so, is this chair NHS [ ]  or Private [ ]

**PERSON’S DETAILS**

|  |  |
| --- | --- |
| **Name** (Mr/Mrs/Miss)      **Address:**      **Post Code:** (essential)       **D.O.B**.      **Telephone No:**      **Delivery Address:** (if different)       | **CHI No:** (Mandatory)      **G.P.** **Tel No:** **Community OT:** ( if known)      **Based at:** **Next of kin/carer:** **Contact No:**  |

*Please include details of current diagnosis/reason for referral*

**DIAGNOSIS**

*It is important to include information such as continence, cardiac/respiratory problems, infectious conditions, previous amputations, cognitive difficulties, visual difficulties or behavioural issues that are relevant.*

**PAST MEDICAL HISTORY**

 1. Please indicate the person’s current level of mobility: i.e. none, transfers only, walks short distances

2. How does the person transfer?

 **Independently** [ ]  **Assistance of one** [ ]  **Assistance of two** [ ]  **Hoisted** [ ]

3. How often will the chair be used?

 **Once a week** **[ ]  2 – 3 times a week** **[ ]  4 – 5 times a week** **[ ]  Daily** **[ ]**

**CURRENT ABILITY AND ANTICIPATED USAGE**

4. Will the person be self-propelling? **No** [ ]  **Yes** [ ]

 If yes, is the person medically fit to self-propel? **No** [ ]  **Yes** [ ]

5. Is the person at risk of pressure sores? **No** [ ]  **Yes** [ ]

 If yes, please indicate level:

 **Existing pressure sore** **[ ]  Previous pressure sores** **[ ]  Where?**

 **Very High Risk** **[ ]  High Risk** **[ ]  At risk** **[ ]**

 **Waterlow scale:**

6. Can the person relieve pressure independently?  **No [ ]  Yes [ ]**

7. Is the person currently using any pressure relieving equipment? **No [ ]  Yes [ ]**

 If yes, **please state what equipment:**

8. Is the person able to sit in a chair without additional support? **No [ ]  Yes [ ]**

 If no, please indicate/describe what may be required:

**NEW CHAIR REQUIREMENTS**

*Please indicate which type of chair is required*

Manual **Self-propelling [ ]** (Only if the person **Attendant propelled** [ ]

 is medically fit to self-propel. If not known,

 please refer to GP prior to sending referral)

 **Energy efficient (active user)** **[ ]  Buggy** **[ ]**

Powered **Yes** **[ ]** If yes, please complete Powerchair Pre Assessment Questionnaire

Has person been trialled successfully in a particular size/style of wheelchair? **No** **[ ]  Yes** **[ ]**

If yes, please indicate details (including size trialled, type of cushion etc):

**A 2” cushion is issued as standard.** Please indicate if an alternative is required:

Additional information/equipment required

**Measurements**

**It is essential that this section be completed accurately for correct issue of a wheelchair.**

Height:       Weight:

****

 A. Seated width:

 B. Thigh length:

 C. Knee to heel:

**** **

D

E

 D. Seat to Shoulder:       E. Seat to Head:

**ENVIRONMENTAL**

When a request for a non-standard wheelchair is made (e.g. over 18”/46cm seated width) there can often be issues with access around the person’s house. To ensure that we can deliver the wheelchair as quickly as possible, please include details of internal and external access of the property that the wheelchair will be used at:

Please also provide the narrowest door width and indicate which door this is:

***in/cm Room:***

**REFERRERS DETAILS**

|  |  |
| --- | --- |
| Person requesting/authorising referral:Name:           Designation:      Address:      Email:      Post Code:       Tel No:       | Person to contact in case of query (if different) Name:      Designation:      Address:      Email:      Post Code:       Tel No:       |

      (Signature)

Date:

PLEASE CHECK NATIONAL CRITERIA BEFORE APPLYING

For further information on how to correctly complete this referral please refer to guidelines or visit our electronic training resource at:

<http://www.rrheal.scot.nhs.uk/what-we-do/programmes-and-events/wheelchair-assessment-tool.aspx>

PERSON’S DETAILS

The CHI number is mandatory on all forms/reports from June 2006. Please complete this section fully including postcode.

DIAGNOSIS

The information provided in this section helps us identify the type of wheelchair most suited to the individual and any future needs. It is the reason that prompted you to refer your client. The more information you can provide the more readily we can provide an appropriate wheelchair. It also helps us check that a wheelchair would be suitable for that individual.

PAST MEDICAL HISTORY

There are a lot of factors that affect an individual’s wheelchair use and type of wheelchair issued. Some such factors are listed on the form. Please give due consideration to these – if not taken into account a person can receive an unsuitable wheelchair that exacerbates a problem or creates others, rather than resolving them.

PERSON’S CURRENT ABILITY AND ANTICIPATED USAGE

The purpose and usage of the wheelchair is required and helps us prioritise peoples’ needs. The amount of time spent seated at any one time helps regarding pressure needs and issuing an appropriate cushion for the wheelchair.

It is important for us to know if the individual is fit to self-propel, if this is what has been requested. For some diagnoses, self-propelling can be contraindicated.

It is vital for us to know when a patient is at risk of or has a pressure sore so that we can accommodate this risk. If an individual already uses pressure relieving equipment it can save us trying products unnecessarily.

Transfer method used helps us plan visits and clinics in advance to ensure we have appropriate transfer equipment available in order for us to carry out thorough assessments.

The reason we ask how a patient can sit in a chair is to determine whether further support is required in the wheelchair i.e. postural belt (pelvic), lateral supports, headrest, harness etc. Important examples of issues are leaning to one side (e.g. a weakness), slipping down chair (e.g. low tone/spasm). If you have tried something already please let us know how successful it was.

NEW CHAIR REQUIREMENTS

This is the type of chair you require for your patient. Please note ‘buggy’ is for young children. If you have used a wheelchair before that was successful please let us know the size/style.

Additional information is anything that you think is relevant to the referral for the wheelchair or for anything not covered previously. If you are unsure whether we need information feel free to note this down and we will consider this.

*NB All standard wheelchairs from NHS Highland are supplied with armrests, footplates and a cushion.*

ENVIRONMENTAL

There are standard sizes held in stock (16x16”, 17x17”, 18x17”) but any out with these ranges require to be ordered for individuals. It is important with larger wheelchairs that we can ensure that it will access the person’s home. It is crucial therefore to complete this section when the person’s hip width is greater than 18” to ensure no access difficulties occur.

MEASUREMENTS

We cannot stress the need for these to be as accurate as possible to prevent a chair of the wrong size being delivered. Please note that due to the demands on our service, many of our patients are sent their wheelchair and are not seen by the service. If the measurements are inaccurate your patient may receive an unsuitable wheelchair that may place them in discomfort or pain, or increase their risk of pressure sores.

All measurements should be taken with the person in a seated position wherever possible. If not, please indicate i.e. lying down.

A) Seated width Measured across the hips, this is a *straight-line measurement and does not conform to their body*

 *shape*. This lets us determine seated width of wheelchair.

B) Thigh length This is the measurement from the back of the bottom to behind the knee when seated. It is used

 to calculate the required seat depth.

C) Knee to heel This measurement is taken from immediately behind the knee to the person’s heel, when their

 foot is placed flat (if possible) on the floor/footplate. It is used to calculate the required height of

 the footrests.

D) Seat to shoulder This is measured from the seat to the top of the shoulder, when the person is in the usual

 seated position. This indicates the required height of back canvas.

E) Seat to head. This is the measurement from the seat to the top of the patient’s head, in the usual seated

 position. It is used to calculate the height of backrest extension required, e.g. if the person will

 be travelling in a vehicle whilst in their wheelchair.

ANY FORMS NOT COMPLETED FULLY WILL BE RETURNED TO YOU CAUSING A DELAY, SO PLEASE INDICATE WITH N/A, OR A LINE THROUGH, ANY SECTIONS THAT ARE NOT APPLICABLE.