# Oxfordshire Wheelchair Service Referral Form

*Please complete all fields. Incomplete referral forms will be returned.*

## Notes re eligibility:

* If the patient only needs the wheelchair outdoors, they are eligible for a standard steel wheelchair only.
* Powered chairs can only be issued to patients who need to use them indoors (cannot functionally walk or self-propel a manual wheelchair) and are able to drive the chair safely themselves.
* Standard transit wheelchairs are not supplied to nursing home residents.

## Patient details

|  |  |
| --- | --- |
| Surname |  |
| First name |  |
| Address |  |
| Postcode |  |
| Title | [ ] Mr [ ] Mrs [ ] Miss [ ] Ms [ ] Dr [ ] Mx [ ] other (specify) |
| Date of birth |  |
| NHS number |  |
| Telephone no |  |
| Mobile no |  |
| Email |  |
| If care home resident, what status is patient? | [ ] nursing [ ] residential |
| Does the patient present a risk to a lone worker? | [ ] no [ ] yes (give details) |
| Patient travel to outpatient appointments | [ ] own transport[ ] bus/taxi[ ] hospital transport[ ] other |

## Priority

|  |  |
| --- | --- |
| Level of priority | [ ] routine [ ] urgent |
| If urgent, reason | [ ] required for discharge [ ] palliative [ ] pressure sores [ ] health & safety risk |
| Details of urgency |  |
| If required for discharge | Date of discharge: [ ] estimated [ ] confirmed |
| Delivery location for discharge (ward & hospital) |  |
| Phone/bleep for arranging delivery |  |
| Any delivery instructions or access issues? |  |

## Reason for referral

|  |  |
| --- | --- |
| New assessment for: | [ ] self-propelled [ ] attendant [ ] powered [ ] buggy [ ] posture [ ] pressure |
| Review due to: | [ ] growth [ ] discomfort/pain [ ] deterioration [ ] pressure sores [ ] other |
| Additional information |  |
| Does patient currently have a wheelchair? | [ ]  no [ ] yes – from OWS [ ] yes – other NHS [ ]  yes – private [ ]  yes - unknown |
| *What wheelchair do they have?* | [ ]  self-propelled manual [ ] attendant manual [ ] powered [ ] not known |
| Where will the wheelchair be used? | [ ] outdoors only [ ] indoors at home [ ] indoors & outdoors |
| How often will the wheelchair be used? | [ ] every day [ ] at least 3 times per week [ ] less than 3 times per week |
| How long per day will the wheelchair be used? | [ ] up to 3 hours [ ] 3-6 hours [ ]  more than 6 hours |
| Who will push the wheelchair? | [ ] attendant [ ] user [ ] both |
| Further assessment required? | [ ] no [ ]  yes |
| Home visit required? | [ ] no [ ]  yes – no safe wheelchair to travel in [ ] yes – other (please specify) |
| Equipment requested (if known) |  |

|  |
| --- |
| **Seat width (SW):** measure at the widest part of the hipMeasure a straight line, ensure the tape measure does not bend. |
| **Seat depth (SD):** from the back of the knees to the rear most part of the bottom |
| **Calf length (CL):** from the back of the knee to the floor/under the heel |

**SW**

**CL**

**SD**

## Physical information (see diagram for how to measure)

|  |  |  |
| --- | --- | --- |
| Height |  | [ ] metres[ ] feet/inches |
| Weight |  | [ ] kg [ ] stone/pounds |
| Height/weight | [ ] estimated [ ] measured |  |
| Seat width |  | [ ] cm[ ] inches |
| Seat depth |  | [ ] cm[ ] inches |
| Calf length |  | [ ] cm[ ] inches |

## Functional information

|  |  |
| --- | --- |
| Able to self-propel? | [ ] yes [ ] no |
| Walking ability - indoors | [ ] independent [ ] with assistance/aids [ ] unable to walk |
| Walking ability - outdoors | [ ] independent [ ] with assistance/aids [ ] unable to walk |
| Mobility status | [ ] deteriorating [ ] stable [ ] improving |
| Transfer method | [ ] independent [ ] with assistance [ ] with aids [ ] hoist  |
| Sitting balance | [ ] able to sit unaided [ ] needs support |
| *Postural issues (if known)* | [ ] scoliosis [ ] kyphosis [x] hip/knee limitations (give details)  |

## Medical details

|  |  |
| --- | --- |
| Diagnosis/es | [ ] stroke [ ] cerebral palsy [ ] spinal cord injury [ ] Parkinson’s [ ] diabetes [ ] muscular dystrophy[ ] MND [ ] brain injury [ ] multiple sclerosis [ ] dementia [ ] amputation (specify side & level) [ ] other (please specify) |
| Does the patient have learning disabilities? | [ ] yes [ ] no |
| Does the patient currently have a pressure sore? | [ ] yes [ ] no |
| If yes, state location and grade |  |
| Is the patient at high risk of pressure sores? | [ ] yes [ ] no |
| If yes, give risk factors |  |
| Doe the patient have epilepsy or seizures? | [ ] yes [ ] no |
| If yes, give details |  |

## Next of kin details

|  |  |  |  |
| --- | --- | --- | --- |
| *Name* |  | *Relationship to patient* |  |
| *Phone no* |  | *Email* |  |

## GP details

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Practice name |  |
| Address |  | Telephone no |  |

## Referrer details

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Email |  |
| Profession |  | Telephone no |  |
| Availability |  | Bleep |  |
| Address |  | Date of referral |  |

Please return this form to owsadministration@ouh.nhs.uk