# 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 hip  Measure 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 |  | metresfeet/inches |
| Weight |  | kg stone/pounds |
| Height/weight | estimated measured |  |
| Seat width |  | cminches |
| Seat depth |  | cminches |
| Calf length |  | cminches |

## 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 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](mailto:owsadministration@ouh.nhs.uk)