THERAPY SERVICES - Referral to Wheelchair Services

Please complete all sections and send via secure email to wheelchairs.agh@nhs.net or fax to 01535 294684

NHS Airedale NHS Foundation Trust

Patients must meet ALL of the following criteria to be assessed for an NHS wheelchair (TICK ALL)

☐ Registered with a GP in the Airedale, Wharfedale & Craven clinical commissioning area incl Bentham
☐ Lawfully entitled to reside in the UK and to receive NHS treatment for use in their own home
☐ Has an identified long term medical condition including palliative care needs requiring a wheelchair
☐ Has a long term* mobility problem and is classified as unable to, or virtually unable to walk indoors

*Long term is more than 6 months

Wheelchair services **DO NOT PROVIDE**

- Wheelchairs for short term use
- Adult wheelchairs for occasional outdoor use only
- Wheelchairs in the place of a suitable static seat
- Powered outdoor only wheelchairs
- Mobility scooters
- Wheelchairs for shared use

CLIENT DETAILS **REFERRAL DATE** ________________

Surname	DOB
Forename Title Mr / Mrs / Miss / Dr / Other	NHS No.
Address Postcode	Telephone Numbers Day Number : Evening Number: Mobile Number:
Carer's name, address and telephone number:	Is this request ☐ urgent or ☐ routine

Is the client an In-patient? ☐ Yes Ward… ☐ No

Referrer's Name & professional designation	GP's Name and Address
Designation: Tel No Fax No Signature	Tel No Fax No Signature

Ethnicity:
Language (If not English): Interpreter required: ☐ Yes ☐ No

Can the client attend clinic: ☐ Yes ☐ No Please tell us why if not ______________________

Does the client require transport ☐ Yes ☐ No Type of transport required (see overleaf)
SC☐ T1☐ T2☐ W1☐ W2☐ STR☐ ESC☐

Please tell us any known risks to staff

Please tell us if there are any safeguarding concerns

DIAGNOSIS, CURRENT MEDICATION & PAST MEDICAL HISTORY relevant to this referral ONLY include any hearing, eyesight or communication impairments

CLIENT MEASUREMENTS

Client height (m)		Client weight (kg)	
Distance across widest part of hips when seated (cm)			

CURRENT CLIENT MOBILITY

☐ Unable to walk ☐ Limited indoors can walk with aid ☐ Limited Outdoors

Can the client transfer independently? ☐ Yes ☐ No If No please specify:

PLEASE TELL US WHY YOU ARE REFERRING FOR A WHEELCHAIR ASSESSMENT

Please tell us the type of assessment you want us to do

Manual Transit ☐

Manual Self Propelling ☐ Please confirm can self propel, no heart or breathing conditions

Indoor Powered ☐ No outside steps or access issues, room for the chair

Indoor/Outdoor Powered ☐ No epilepsy or seizures, good visual acuity no eyesight issues or reasons why a powered chair would not be safe

Please tell us about any hearing, eyesight or communication impairments

Expected patient outcomes (tick as many as applicable)

☐ Increase mobility in the home ☐ Increase mobility outdoors ☐ Reduce risk of falls

☐ Improving functional ability ☐ Maintain or increase independence ☐ Pressure relief

How often do you expect the client to use a Wheelchair?

☐ Occasionally ☐ Daily ☐ Weekly

For how long?

☐ Short periods ☐ 2-3 hours ☐ All day without relief

What will the main use of the Wheelchair be?

☐ Moving around the house ☐ Social Outings ☐ Shopping ☐ Day/Training Centre

☐ School/College/Work ☐ Nursing Home ☐ Residential Home ☐ In the garden

Does the client already have a wheelchair? ☐ Yes ☐ No

Clients will be made aware of the Independent Wheelchair Voucher Scheme as part of the assessment.
Has client already expressed interest in the scheme? ☐ Yes ☐ No

Type of transport
SC Driver only saloon car T1 Ambulance, can transfer T2 Attendant W1 Ambulance can't transfer W2 Attendant can't transfer STR Stretcher ESC = escort required 3ML/4ML Bariatric