Central and North West London NHS
NHS Foundation Trust

Camden Provider Services

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CAMDEN & ISLINGTON WHEELCHAIR SERVICE
PAEDIATRIC REFERRAL / REVIEW FORM

CLIENT DETAILS:					
Title		**First Name**		**Surname**	
Parents Names				**Urgency : Reason:**	
Date of Birth				**Client NHS No.**	
Home Address				**Male** ☐ **Female** ☐	
				Full Post Code	
Telephone				**ETHNIC ORIGIN: (optional) Language:**	
Mobile					

School/Nursery Address		
Phone Number		

GP DETAILS (MUST BE COMPLETED):			
GP Name		**GP Tel Number**	
GP Address		**Full Postcode**	

Diagnosis/Past Medical History:

(Please include any relevant reports e.g. recent assessments, current medication etc.)
Date and results of last HIP x-ray (if relevant):
Date and results of last spinal x-ray (if relevant):
Planned Surgery (Known operations / planned surgical interventions):

Other Professionals involved (ie. OT/PT/consultant). Please give details, including contact numbers

Reason for Referral:
Is client/parents aware of the referral? Yes/No

Buggy	o	Attendant propelled wheelchair (A/P	o
Self propelled wheelchair (S/P)	o	Powered wheelchair	o
Seating System	o	Review of needs	o

Please provide detail:

CURRENT EQUIPMENT

Current Wheelchair/ Buggy/ Seating (including accessories):

Static Seating or other positioning equipment on issue/due (e.g. standing frames, lying/seating positioning aids at home and at school):

REFERRER'S DETAILS:

Name		**Profession**	
Work/Dept. Address			
Telephone No.		**Email address**	

MEASUREMENTS (if appropriate)

Please complete all fields including height and weight. Incomplete referrals will delay provision.

(To be taken at widest point)

Metric ☐ Imperial ☐

a

b

c

d

Height: **Weight** :

HOUSING

Type of Housing:

House ☐ Flat ☐ Other ☐ State :

Lives with:

Access Lift ☐ Stairs ☐ Ramp ☐ Restricted Access ☐

Is there adequate turning space in all areas? (e.g. 1.2 m) Yes ☐ No ☐

Is the client waiting re-housing? Yes ☐ No ☐

Any relevant measurements or space restrictions to consider:

POSTURAL ASSESSMENT:
Please provide detail of client's current postural status:
Complete only relevant section.

	In sitting	In supine
Head/Neck		
Trunk/Spine		
Pelvis		
Upper Limbs		
Lower Limbs		

Chailey Box sitting ability:

Is posture : correctable o fixed o

Tone:

Tone Management:

FUNCTION (please attach risk assessment if relevant)

Cognitive abilities:

Sensory Needs:

Behaviour:

Continence:

Respiratory :

Feeding:

Hand Function:

Mobility (indoors and outdoors) :

Transfer method:

Orthoses (on issue/due):

Parents/Carers Needs:

REFERRER RECOMMENDATION AND CLINICAL REASONING

DIRECT EQUIPMENT PRESCRIPTIONS: (standard buggies and standard manual wheelchairs)

MODEL REQUIRED:

Maclaren buggy ☐ Attendant Propelled Wheelchair ☐ Self Propelled Wheelchair ☐

Wheelchair colour (if available) :
Red ☐ Black ☐

Blue ☐

Preferred model of wheelchair (please consult wheelchair service product folder) :

CUSHION REQUIRED:

Standard foam : YES ☐ NO ☐

Thickness : 2" ☐ 3" ☐

Moulded cushion: YES ☐ NO ☐

Mercury junior ☐ Flotech lite ☐

ACCESSORIES REQUIRED (Nb. Standard lapstraps are automatically supplied with wheelchairs)

Does client require any accessories? YES ☐ NO ☐

Special padded lapstrap ☐
Reason:

Standard tray ☐
Reason(Trays are issued for postural reasons only):

Other:

NB. All other accessories will require an assessment by a wheelchair therapist.