Central and North West London NHS
NHS Foundation Trust

Camden Provider Services

CAMDEN & ISLINGTON
WHEELCHAIR SERVICE REFERRAL FORM

For Occupational Therapists, Physiotherapists and Assistants

The Peckwater Centre
6 Peckwater Street
Kentish Town
London NW5 2TX

Tel: 020 3317 5040
Fax: 020 7485 5306
Email: candi.wheelchairservice@nhs.net

CLIENT DETAILS: **NHS No. …………………………………..**

Title ……… Surname …………………………………….. Forenames ………………………………………………

Date of Birth: ………..…………………………………….. Female ☐ Male ☐

ETHNIC ORIGIN (*Please refer to attached sheet):* …………………………………………………………………….

First Language: ……………………….. Can the client speak English?...

Home/Discharge Address: ………………………………………………………………………………………

……………………………………………………………………… **Full Postcode** …….………………………

Is client in receipt of continuing care funding? Yes ☐ No ☐

Telephone no. Home: ………………………………… Mobile: …………………………………………………..

Email Address: ……………………………………………………………………………………………..

Delivery address (if different from above): ……………………………………………………………………….

……………………………………………………………..….. ……… Tel No:.……………………………………..…

Access for delivery (Nb. Chairs are delivered between 9am-2pm weekdays only):………………...…………………

Contact person's name for delivery or interpreting:…………………………Telephone no:..………….…………….

Relationship to Client: …………………………………….

IMPORTANT: The following GP details <u>MUST</u> be completed, otherwise the referral will be returned. Only clients with Camden/Islington PCT GPs will be accepted by this service.

GP's Name ……………………………………………….…….. GP Telephone No. …………………………………..

GP Address …………………………………………………………………….…………GP Post Code ………………..

REASON FOR REFERRAL (please complete A or B)

A. New Referral: Assessment required for:

Attendant propelled wheelchair (A/P) ☐ Self propelled wheelchair (S/P) ☐
Powered indoor chair (EPIC) ☐ Powered indoor / outdoor chair (EPIOC) ☐

****WCS does not provide power chairs for outdoor use only****

B. Current Wheelchair User:

Model and accessories currently used: ………………………………………………… NHS ☐ Private ☐

Reason for reassessment:………………………………………………………….……………………………..

ASSESSOR'S DETAILS: Occupational Therapist ☐ Physiotherapist ☐ Assistant ☐

Name ……………………………………………………………………….. Date: …………………………….

Work/Dept. Address ………………………………………………………………………………………………

Telephone No:.…………………………………………… **Email address:**……..……………………………………

NATURE OF DISABILITY / DIAGNOSIS (Please include date of diagnosis if appropriate):

………..

………

Does client have past history or at risk of **DVT?** ……………………………………..…………………………….

………...

Are there any known risks that may affect staff's safety (e.g.history of violence)?

Details:……….

Please tick if client has any of the following and provide additional information:

Visual impairment ☐ Cognitive deficit ☐ Perceptual deficit ☐ Learning Disability ☐

Details:
……

………..

MOBILITY:

Walks independently indoors ☐

Walks with assistance indoors (with / without walking aid) ☐ Aid: …………………………………..

Unable to walk ☐

Any other comments (inc. prognosis)……………………………………………………………………………

TRANSFERS:

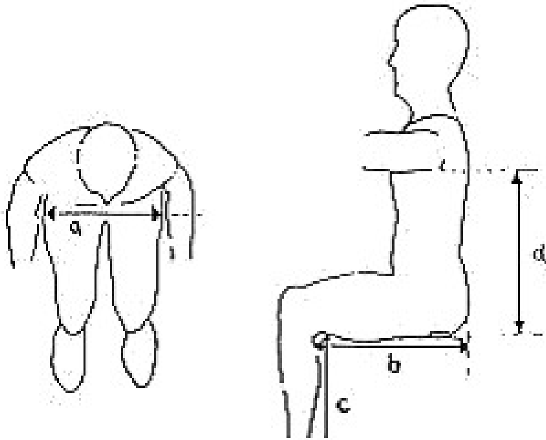
Is client able to transfer?

Independently ☐ With assistance of one ☐ With assistance of two ☐ Unable ☐

Method of transfer (please circle): standing pivot transfer board standing hoist hoist

MEASUREMENTS (Incomplete referrals will delay provision)

Height ……………… Weight.…………….. (***must*** *be completed)*



A ……………………..……pelvic hip width

B……………………..…….Buttock/thigh depth

C…………………….……..lower leg length

D…………………….……..seat to axilla

****Ensure the individual is seated on a firm surface and sitting as upright as possible.**

Section C: Function:

Push up for relief: Total ☐ Partial ☐ Unable ☐

Can the client lean forwards in the wheelchair to pressure relive? Yes ☐ No ☐

Is a particular seat height required for transfers?……………………………………………………………………

Client moving Cushion from wheelchair: Independent ☐ Assisted ☐

Urinary Continent: Yes ☐ No ☐
Faecally Continent: Yes ☐ No ☐

Continence management:…………………………………………………………………………………………………..

Other Information:……………………………………………………………………………………………

PRESSURE CARE:

Does the user have a HISTORY of pressure area? Yes ☐ No ☐

If YES, where did the pressure areas occur? BED ☐ WHEELCHAIR ☐ OTHER ☐

Where did the CURRENT pressure sore occur? BED ☐ WHEELCHAIR ☐ OTHER ☐

Please indicate site and grade of PREVIOUS and CURRENT pressure sore.

SITE	Previous History & Grade	Current History & Grade
Sacrum		
Crease/Coccyx		
Trochanter (L/R)		
Ischium (L/R)		
Pre-Ischium (L/R)		
Thigh(L/R)		

Perssure area score (please provide copy of score if possible)**:**

Waterlow:…………………………………………. Walsall:………………………………………

SOCIAL FACTORS:

Lives alone ☐ with family ☐ with carers ☐ Sheltered Housing ☐

Residential Home ☐ Nursing Home ☐ other, please state ……………………………………..

Details of care package (if appropriate): ……………………………………………………………………

………

Place of employment (if appropriate): ……………………………………………………………………….

Day Centre (if appropriate): ……………………………………………………………………………………

Transportation Method: …………………………………………… **Model:** ………………………………….

ENVIRONMENTAL FACTORS:

Has a home visit been carried out? Yes ☐ No ☐

If possible, please send the report with the referral.

Type of Housing:

House ☐ Flat ☐ Other ☐ ……………………………………………………………………

Has client been tried in wheelchair in own home environment? Yes ☐ No ☐

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

Is the home environment wheelchair accessible? Yes ☐ No ☐

Do environmental factors affect wheelchair prescription? Yes ☐ No ☐

Details: ……………………………………………………………………………………………………..

FOLLOW UP:

Will client be followed up by any professional in future? Yes ☐ **No** ☐

Please give details and contact name / telephone number:……………………………………………………

Any further comments? ………………………………………………………………………………………..

………

Does the client have any communication difficulties that the Wheelchair Service should know about (e.g. unable to use phone, requires large print letter)?

Yes ☐ No ☐ Details:………………………………………………………………………………….

THE VOUCHER SCHEME:

If the client does not want the wheelchair provided on the NHS, he or she can contribute to the cost of a more expensive wheelchair, using the Voucher Scheme. The Voucher option will require a clinic appointment. Please refer to the Resource File for more information.

USEFUL INFORMATION WHEN CONSIDERING WHEELCHAIR SIZE:

- The weight limit of attendant propelled and self propelled wheelchairs is 19.6 stone / 125kg.
- The overall width of a standard **attendant propelled** wheelchair is approx 7” greater than seat width. The length of a 17” x 17” a/p chair is approx 35” (88.9cm).
- The overall width of a standard 17” **self propelled** wheelchair is approx. 8” greater than the seat width. The length of a 17” x 17” s/p chair is approx. 40” (101.6cm).

A. MODEL AND SIZE OF STANDARD WHEELCHAIR REQUIRED/SUGGESTED (please tick):
*If your client requires any wheelchair other than a standard model, they may need a clinic appointment.

Attendant Propelled Wheelchair ☐ **Self Propelled Wheelchair** ☐

(15x16”) 38x41 cms ☐ (16x16”) 41x41 cms ☐ (17x17”) 43x43 cms ☐

(18x17”) 46x43 cms ☐ (19x18”) 48x46 cms ☐

Other (please state) ………………………………………………………………………………………..

Has client been tried in recommended model? Yes ☐ No ☐

Wheelchair required to facilitate hospital discharge? Yes ☐ No ☐ Discharge date ….……………

We need at least 1 weeks notice for standard equipment. Specialist equipment e.g. tilt in space, will require a wheelchair service appointment

CUSHION DETAILS:

Is a standard foam cushion required? Yes ☐ No ☐ State Depth: 2” ☐ 3” ☐

If No, has client already got a suitable cushion? Yes ☐ No ☐

If an alternative cushion is required, **please state below:**

Castletop (3” thick, flat but contouring, castlelated foam, medium risk) ☐

Sunmate (3” thick, flat but contouring, memory foam, medium risk) ☐

Pudgee (3” thick, flat with high contouring, memory foam, med/high risk) ☐

Flotech Lite/Mercury100 (3” thick, contoured foam, medium risk) ☐

Mercury 200 (3” thick, contoured foam, medium/high risk) ☐

Flotech Solution (3” thick contoured foam with gel cover, high risk) only provided for those who currently have/history of pressure sores ☐

ACCESSORIES:

Does client require any other accessories? Yes ☐ No ☐ If so, please give details…………………

……

B. IS A CLINIC ASSESSMENT REQUIRED FOR:

A high performance wheelchair: Yes ☐ No ☐

Postural support: Yes ☐ No ☐ Pressure care: Yes ☐ No ☐

Does client require transport to a clinic assessment? Yes ☐ No ☐

We request that the primary therapist attends wherever possible.
Would you like to be notified of the appointment? Yes ☐ No ☐

Client ethnicity (tick as applicable)

A White

British
Irish
Greek or Greek Cypriot
Albanian excluding Kosovan
Kosovan
Any other White background – *specify if you wish:*

B Mixed

White and Black Caribbean
White and Black African
White and Asian
Any other Mixed background – *specify if you wish:*

C Asian or Asian British

Indian
Pakistani
Bangladeshi
Any other Asian background – *specify if you wish:*

D Black or Black British

Caribbean

African:
Nigerian
Somali
Congolese
Any other African background – *specify if you wish:*

Any other Black background – *specify if you wish:*

E Chinese or other ethnic group

Chinese
Any other group – *specify if you wish:*

Client's first language: ………………………..