

The Peckwater Centre
6 Peckwater Street
London
NW5 2TX
Tel: 020 3317 5040
Fax: 020 7485 5306

Manual Wheelchair Referral Form
GP/District Nurse/Social Worker

Email: candi.wheelchairservice@nhs.net

It is essential that all of this form is completed

User Details			
Surname:		Forenames:	
Male <input type="checkbox"/> Female <input type="checkbox"/>		Home Address:	
Date of Birth:			
NHS No:			
Ethnicity: see page 4		Postcode:	
First Language:		Tel No:	
<i>If user unable to speak English, or has communication difficulties:</i>			
Contact Person:		Tel No:	

GP Details:		
Name:	Tel No:	
	Email:	
Address:	GP STAMP (if available)	

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

DISABILITY/DIAGNOSIS/ PMH (past medical history):
Please include any relevant reports e.g. recent assessments, current medication etc.
.....

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

Reason for Referral:	
<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	
Are there any known risks that may affect staff's safety (e.g. History of violence)?	
<p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
Details	
<p>.....</p>	
Please tick if client has any of the following and provide additional information:	
<p>Visual impairment <input type="checkbox"/> Cognitive deficit <input type="checkbox"/> Perceptual deficit <input type="checkbox"/> Learning Disability <input type="checkbox"/></p>	
Details	
<p>.....</p>	
Does the user already have a wheelchair?	<p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Referrers Details: Name (if not client's GP):	Profession:
Work Address:	Tel No:
	E-mail Address:
Referrer's Signature:	Date:

Please complete all sections:

Wheelchair Type Required:
<p><input type="checkbox"/> Transit Wheelchair (the wheelchair user is pushed by a carer)</p> <p><input type="checkbox"/> Self-Propelling Wheelchair (the user pushes the wheelchair themselves) <i>*GP's - Please complete medical consent section at bottom of page 3*</i></p> <p><input type="checkbox"/> Powered Wheelchair <i>Nb. Powered wheelchairs are <u>not</u> supplied for outdoor use only, i.e. to people who manage walking or self-propelling indoors. Please contact Scotability on 020 7974 2420, or the Disabled Living Foundation on 0207 289 6111 for information on how to get a powered chair for outdoor use. A full list of the eligibility criteria can be obtained by contacting the wheelchair service.</i></p>

Where is the user intending to use the wheelchair?	
Inside the home only <input type="checkbox"/> Inside the home & outdoors <input type="checkbox"/> Outdoors Only (including public buildings) <input type="checkbox"/>	
How often is the user intending to use the wheelchair?	
Daily <input type="checkbox"/> +3 Times a Week <input type="checkbox"/> Once a Week <input type="checkbox"/> Occasional <input type="checkbox"/>	
MOBILITY:	
Walks independently indoors <input type="checkbox"/>	
Walks with assistance indoors (with / without walking aid) <input type="checkbox"/> Aid:	
Unable to walk <input type="checkbox"/>	
Any other comments (inc. prognosis).....	
Who will push the user in the wheelchair? (If required)	

Other Details:

Is the user able to attend the Peckwater Centre for an assessment for a wheelchair?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Will user need ambulance support to attend clinic?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Additional Information:		
.....		
.....		
.....		
.....		

*** GP use only - Medical Consent to Self-Propel:**

In your opinion does the user have any medical conditions that may affect their ability to self-propel? (If yes, please state details)	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
<u>Details:</u>	
If yes, please tick the relevant box below:	
<input type="checkbox"/> The client is <u>not</u> medically fit to manually self-propel a wheelchair. <input type="checkbox"/> The client is medically fit to self-propel indoors only or outdoors with supervision/standby assistance. <input type="checkbox"/> The client is medically fit to self-propel any distance, with no supervision or assistance required.	
GP Signature:	Date:

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: