Referral Form

Patient's equal access form

Why we need you to complete this form

We have a legal duty to ensure that patients accessing our services are treated fairly.
Please complete this form to help us comply with our duty.

This form can be completed on paper or electronically, (check boxes can be clicked with the mouse ☒). Do not change the format or structure of this form, corrupted forms will be rejected.
Instructions how to send this form are at the end of the document.

A delay in the processing of your referral may occur if you do not complete all the sections on this referral.

Consent:		
Has the client given consent for this referral?	☐ Yes	☐ No

1. Personal Details:	
Title: Mr / Mrs / Ms / Miss / Mstr / Other	Gender:
Surname:	First Name:
Date of Birth:	NHS No:
Home Address:	
	Post Code:
Home telephone:	Mobile:
Preferred method of contact:	Email Address:

2. GP Name:	Practice:	
Address:		
Post Code:	Telephone No:	
Is the Service User under Continuing Healthcare?	☐ **Yes**	☐ **No**
Additional Information relating to Continuing Healthcare?		

3. Next of Kin:	Nominated Contact Person:
Relationship:	Relationship:
Telephone no:	Telephone no:

Power of Attorney:

☐ N/A ☐ EPA ☐ LPA (Finance/ Property) ☐ LPA (Health/Welfare)

Details: _____

_____

_____

Children's Referral Only:

Primary Carer: _____

Person with Parental Responsibility: _____

Is this child subject to safeguarding plan? ☐ Yes ☐ No

Name of School / College: …… ☐ N/A

4. Language

Does the client speak English? ☐ Yes ☐ No

Do they need a qualified interpreter? ☐ Yes ☐ No

If yes, please indicate which language: _____

What is their preferred language? _____

5. Reason for referral

Is the wheelchair essential for discharge?	☐ Yes	☐ No	Discharge Date: _____

Reason for referral / re-referral: _____

_____

Primary medical condition: _____

Is the client affected by any of the following?

Terminal Condition ☐ **Current Pressure Sore/ Grade** ☐ **Wheelchair required for Falls Prevention** ☐

Bed Bound ☐ **Epilepsy/Blackouts** ☐ **Heart and/or Respiratory Conditions** ☐ **Visual Impairment** ☐

If yes to any of the below, please explain: _____

Allergies ☐ **Cognition** ☐ **Surgery** ☐ **History of Falls** ☐ **History of Pressure Sores** ☐

Epilepsy ☐ if yes, when was the last seizure?

Is the client's condition:	☐ Stable	☐ Deteriorating	☐ Rapidly deteriorating
Medication: _____			
*** Height** (approx)	*** Weight** (approx)		

6. Wheelchair Requirement

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

Has the client trialled a wheelchair or cushion ☐ Yes ☐ No

If yes, who supplied it and what wheelchair / cushion is it? _____

_____

What type of wheelchair would you like to be assessed for?

- ☐ Self-propel (push by yourself)
- ☐ Attendant propelled (pushed by someone else) Please state by whom: _____
- ☐ Buggy (for children up to 5 years)
- ☐ Power wheelchair (powered wheelchairs are not provided for outdoor use only)

Where will the wheelchair be used? ☐ Indoors ☐ Outdoors

(tick as many that apply)

How often will the wheelchair be used?

☐ 1 day a week or less ☐ 2-3 days a week ☐ 4 days or more

Will the wheelchair be required for: ☐ Less than 6 months ☐ More than 6 months

Please note we only issue wheelchairs for long term (more than 6 months) need and those who have a life limiting condition.

How does the person move about *(state aides used, number of people required, distance)*

Indoors: _____

Outdoors: _____

How does the client transfer from bed?

☐ On own ☐ With assistance of one ☐ With assistance of two

☐ Transfer board / rotor stand ☐ Hoisted/unable ☐ Other: _____

Does the person have help at home?

☐ Lives alone, independently ☐ Lives alone, carer assistance

☐ Lives with family ☐ Lives with family, plus carer assistance

Does the client have any static seating being used at home ☐ Yes ☐ No

If yes, which one? _____

Wheelchair delivery- please let us know where you'd like the equipment to be delivered. (please provide full address)

Home ☐ Yes ☐ No

Hospital (address, ward, contact name and number): _____

_____

_____

Other: _____

_____

_____

7. This section is compulsory for Health Professionals to complete

***Non - professionals please complete to your best ability**

Posture (if you are able to fill in the information below, please do to the best of you knowledge):

Sitting balance:	☐ Independent	☐ Short periods	☐ With assistance of: _____

Pelvis:	☐ Neutral	☐ Oblique	☐ Rotated	☐ Anterior Tilt	☐ Posterior Tilt
Spine:	☐ Mid Line	☐ Kyphosis	☐ Scoliosis	☐ Lordosis	☐ Leaning
Trunk:	☐ Mid Line	☐ High Tone	☐ Low Tone	☐ Variable	☐ Fixed Deformities
U/Limbs:	☐ Mid Line	☐ High Tone	☐ Low Tone	☐ Variable	☐ Fixed Deformities
L/Limbs:	☐ Mid Line	☐ High Tone	☐ Low Tone	☐ Variable	☐ Fixed Deformities

Does this person have complex seating needs: ☐ Yes ☐ No

Does this person see any other health professionals? If so please provide contact details:

Discipline	Organisation	Contact Details

Consultant:		
Occupational Therapy:		
Physiotherapy:		
Social Work:		
Other:		

Any other alerts (behaviour, substance use, MRSA, etc.)?

_____

8. Referrer details

☐ The service user is aware this referral is being made

☐ I have completed this referral form truthfully and accurately

☐ If possible, I would like to be invited to the wheelchair and seating assessment

Are you a trusted prescriber? Yes ☐ No ☐ If yes, please state your Prescriber No:_____

Signed: _____ Date: _____

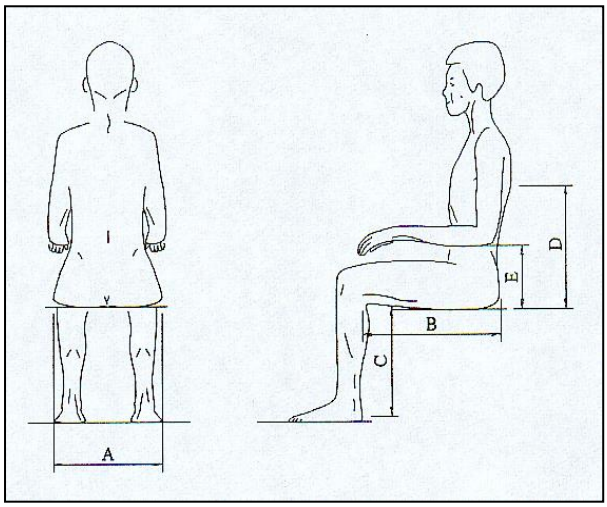
Name: _____ Relationship: _____

Address: _____

Post Code: _____ Phone: _____

Email: _____

If you are not an Accredited Prescriber stop here and go to section 9

This section if for Accredited Prescribers	
Measurements (body dimensions)	**Note** – measure in sitting using a straight or rigid tape measure
	A – Hip width B – Upper leg length (L) (R) C – Lower leg length (L) (R) D – Height to arm pit E – Elbow height (L) (R) Other:

Cushion?

Is a standard cushion foam required?	☐ Yes	☐ No
If yes, what thickness is required?	☐ 2”	☐ 3”
Is a pressure relieving cushion required?	☐ Yes	☐ No
Details of pressure Sore?	_____	

Accessories?

Does the client require any accessories?	☐ Yes	☐ No
Please state what is required?		
Headrest	☐ Yes	☐ No
Lateral supports	☐ Yes	☐ No
Trunk harness	☐ Yes	☐ No
Pommel	☐ Yes	☐ No
Stump board – right / Left	☐ Yes	☐ No
Elevating leg rest – Right / Left	☐ Yes	☐ No
O2 cylinder	☐ Yes	☐ No

9. Ethnicity

Please indicate the client's ethnic background by ticking☑. (or clicking ☒) one box below This helps to identify earlier treatment for certain illness such as diabetes or high blood pressure, which may affect some patients more than others.

White

☐ British (English / Scottish / Welsh)
☐ Irish
☐ Other White Background

Please specify _____

Mixed

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Other Mixed Background

Please specify _____

Black or Black British

☐ Caribbean
☐ African
☐ Other Black Background.

Please specify _____

Asian or Asian British

☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Other Asian Background

Please specify _____

Other Ethnic Groups

☐ Chinese
☐ Any other ethnic group

Please specify _____

☐ **Not stated**

☐ **Not known**

☐ **Declined to disclose (refused)**

Please ensure all fields are completed. Referrals received with insufficient information will be returned and may lead to a delay in the referral being processed

Please note:

1. For powered wheelchairs it is vital that GP's fill in section 10 in order to process the referral in a timely manner. If this section is not filled out then the referral will be rejected as incomplete.
2. Date of referral received (for wait listing purposes) will only be given when all essential information has been received.
3. Equipment will only be provided for individuals who meet the eligibility criteria for provision.
4. Referrals are waitlisted in accordance with the category of equipment required and their medical needs.

If you have any queries completing this form, please call 020 8664 8860

Please return this form to:

CES Croydon Wheelchair Service
CLIC
3 Imperial Way
Croydon
CR0 4RR
Tel: 020 8664 8860
Email: ceswheelchairs@croydon.gov.uk

10. This section is to be filled in by GP for further information required for clients requesting for powered provision		
Does this person have any condition that would prevent him/her from safely operating an electrically powered indoor/outdoor wheelchair?	☐ Yes	☐ No
If yes, please give reason for this? _____		
Does the client have history of epileptic fits	☐ Yes	☐ No
If yes, when was the last fit? _____		
Are the fits under control?	☐ Yes	☐ No
Other causes of loss of consciousness	☐ Yes	☐ No
Behavioural problems	☐ Yes	☐ No
Recent history of alcohol or substance misuse	☐ Yes	☐ No
Severe tremor/ataxia	☐ Yes	☐ No
Side effects of medication	☐ Yes	☐ No
Visual impairment	☐ Yes	☐ No
Hearing impairment	☐ Yes	☐ No
Cognitive impairment	☐ Yes	☐ No

How to refer – DSX

- Search specialty **'Wheelchair'** and clinic type **'Wheelchair'**
- The commissioned service to refer to is **Croydon Community Equipment Service**
- Click 'send for triage' (blue button)
- Add referral pro forma
- Inform the patient that they will be contacted with a suitable appointment
- There is a waiting list for appointments. Please contact the service for details.
- Any missing information on the referral form can cause a delay to the appointment.