Providing NHS services

Mansfield Wheelchair Service

MAN001 Referral form (to be completed by a Registered Healthcare Practitioner only)

Important Recommendations

- Do not complete from an internet browser (right click and save file to a secure location)
- Use the latest Adobe Acrobat DC Reader
- Dates must be keyed in full DD/MM/YYYYformat
- Use the 'Reset Form' button, when necessary, to clear all entries

Please read Mansfield Wheelchair Service's eligibility criteria and supporting guidance before completing this referral. Complete all mandatory sections to prevent the referral being returned.

Green sections are mandatory for ALL referrals
Orange sections should be completed for all POWERED wheelchair referrals **CHECK ELIGIBILITY AND OUR POWERED REFERRAL GUIDES BEFORE SUBMITTING**
Complete light blue sections for CARE HOME RESIDENTS being referred for transit wheelchairs
Yellow sections should be completed for referrals for CHILDREN

Service user details		GP details	
Title		**GP Name**	
First name		**Nat GP code**	
Surname		**Telephone No**	
DOB		**Surgery name**	
NHS number		**Surgery address**	
Gender		**Postcode**	

Ethnicity			
Building Name			
Home Address Line 1			
Home Address Line 2			
Town			
County		**Postcode**	
Home telephone		**Mobile**	

If this is not the service user's mobile number, please state below whose number it is			
Name		**Relationship**	

Can the Wheelchair Service send texts to this number?	Yes	◯	No	◯
Can the service user access a video appointment? (This could be with help from another person)	Yes	◯	No	◯

Email address			
If this is not the service user's email address, please state below whose it is			
Name		**Relationship**	
By providing this email address, the service user is consenting to communication via email			
Next of kin (NOK) details Copy Main Address			
Name		**Relationship**	
Same address as Home Address?			
Building Name			
Address Line 1			
Address Line 2			
Town			
County		**Postcode**	
Telephone number			
Is this the service user's guardian or attorney?	Yes ◯	No ◯	
Other addresses 1			
Location type			
Building Name			
Other Address Line 1			
Other Address Line 2			
Town			
County		**Postcode**	
Telephone number			
Contact person name (if relevant)			
Job title/relationship to service user			
Other addresses 2			
Location type			
Building Name			
Other Address Line 1			
Other Address Line 2			
Town			
County		**Postcode**	
Telephone number			
Contact person name (if relevant)			
Job title/relationship to service user			

Consent and safeguarding					
Has the service user given consent for this referral?					
Has the service user given consent to share information with other professionals/agencies listed in this referral?					
If service user does not have capacity, who is their guardian or attorney?					
Same as Next of Kin? Copy Next Of Kin Details					
Name		**Relationship**			
Address line 1					
Address line 2					
Address line 3					
Town					
County		**Postcode**			
Telephone number					
Have you gained consent to refer from legal guardian or attorney?					
Is the service user a "looked after" child?	Yes ◯	No ◯			
If yes, who has Parental Responsibility?					
Name		**Relationship**			
Building Name					
Address line 1					
Address line 2					
Town					
County		**Postcode**			
Telephone number					
Are there any safeguarding concerns or risks?	Yes ◯	No ◯			
Are there any risks to staff visiting home address?	Yes ◯	No ◯			
Details:					

Communication, cognition, behaviour and sensory needs				
How does the service user communicate? (pick all that apply)	Verbally (no problem)	☐	British Sign Language	☐
	Some verbal speech but limited	☐	Facial expression	☐
	Picture Exchange Communication System	☐	Makaton	☐
	Electronic communication aid	☐	In writing (by hand)	☐
Communication aid details:				
First language				
Is an Interpreter required for appointments?	Yes ◯	No ◯		

Does the service user have any hearing problems?	
Details, if yes:	
Does the service user have any visual problems?	
Details, if yes:	
Does the service user have any perceptual difficulties?	
Details, if yes:	
Does the service user have any cognitive difficulties?	
Details, if yes:	
Does the service user have any sensory disturbance or processing issues?	
Details, if yes:	
Does the service user need support with any behaviour issues?	
Details, if yes:	

Professionals involved & contact details		
Name	**Profession**	**Contact details (Email/telephone)**

Clinical information	
Primary Diagnosis	
Secondary Diagnosis	
Additional medical information	
Medication	

Does the service user have a recent history (past 12 months) of any mental health issues relevant to safe use of a powered wheelchair?	Yes	◯	No	◯
Does the service user have a diagnosis of epilepsy?	Yes	◯	No	◯
If yes, provide the following details**:** frequency of seizures, duration, night/day, date of last seizure				
Does the service user experience any loss of consciousness?	Yes	◯	No	◯
Details, if yes:				
Does any medication cause side effects (eg drowsiness) that would lead you to advise them against driving or operating machinery?	Yes	◯	No	◯
Known allergies				
Feeding				
Does the service user have any swallowing problems?	Yes	◯	No	◯
Details, if yes				
Does the service user have any breathing difficulties?	Yes	◯	No	◯
Details, if yes:				
Does the service user have:				
Supplementary Oxygen	Yes	◯	No	◯
Tracheostomy	Yes	◯	No	◯
CPAP or Ventilation	Yes	◯	No	◯
Suction	Yes	◯	No	◯
Does the service user have any Aerosol Generating Procedures (AGPs)?	Yes	◯	No	◯
What is the service user's level of continence?				
Details of incontinence management:				
Does the service user have a history of pressure ulcers?				
Details, if yes:				
Does the service user have any existing pressure ulcers?				
Details of management plan:				

If known, what location and category is/are the current ulcer/s?					
Location	**Left or Right** (if applicable)				**Grade**
	Left	☐	Right	☐	
	Left	☐	Right	☐	
	Left	☐	Right	☐	
	Left	☐	Right	☐	
	Left	☐	Right	☐	
	Left	☐	Right	☐	

Is a Community Nurse involved in treatment?				
Is the cause of the ulcer known?				
Details, if yes				
Is service user able to pressure relieve?				
Is there a pressure mattress in place?				
What seating is available for use in addition to a wheelchair?				

Care and support				
Does the service user live alone or with others?				
Does a family member assist with care?	Yes	◯	No	◯
Details, if yes				
Does the service user have paid carers?	Yes	◯	No	◯
Frequency of carer visits				
Please provide any other care support information that is relevant to wheelchair provision				

Movement and function				
Current level of mobility indoors				
Walking aid(s): Enter NONE if appropriate				
Current level of mobility outdoors				
If the service user has a self-propelling manual wheelchair, have you observed them propelling it?	Yes	◯	No	◯
Is the level of mobility				
If the service user is self-propelling a manual wheelchair, is this having a detrimental effect on their condition?	Yes	◯	No	◯

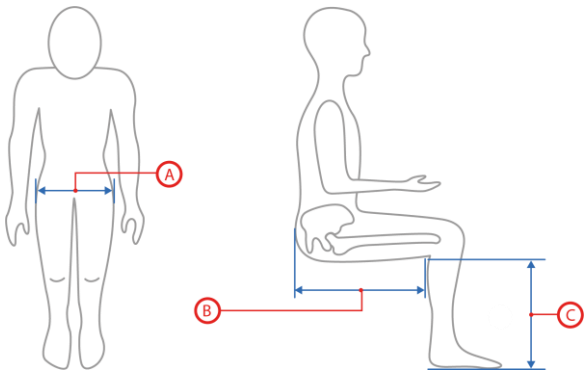
Has the service user had any falls inside their own home?				
Has the cause been investigated?	Yes	◯	No	◯
Details:				
Has the service user had a mobility review by a physiotherapist in the past year?				
Does the service user have use of their hands to control a powered wheelchair? *(alternative control methods are available)*	Yes	◯	No	◯
Ability to transfer (pick all that apply)	Independent without transfer aid(s)	☐		
	Independent with transfer aid(s)	☐		
	Assisted by one person	☐		
	Assisted by two people	☐		
Details of transfer aids (pick all that apply)	No aid(s) required	☐		
	Rails	☐		
	Transfer board	☐		
	Rota stand	☐		
	Standing hoist	☐		
	Full hoist	☐		
Home Environment				
Type of housing				
Ownership				
Is there level access to property?	Yes	◯	No	◯
Details, if no:				
Are adaptations to the property being planned or in progress?				
Details, if yes:				
Does service user have an open referral with social services in relation to home adaptations?				
Details, if yes:				
Are there any identified problems with using a wheelchair inside the home?				
Details:				

Transport details				
Does the service user need to travel in the wheelchair in a vehicle?				
Will/does the service user transfer their wheelchair into and out of the vehicle themselves?	Yes	◯	No	◯
Does the wheelchair need to fold (for storage in the boot of a vehicle)?	Yes	◯	No	◯
Does the service user / main carer have a wheelchair accessible vehicle?				
Does/will the service user drive from their wheelchair?				

Posture				
Can the service user sit unsupported?	Yes	◯	No	◯
If no, please give details of support required:				
Chailey level of sitting, if known				
Has CPIPS or Postural assessment been completed?	Yes	◯	No	◯
Does the service user have any altered tone or movement patterns?	Yes	◯	No	◯
Details, if yes:				
Is there any abnormal spinal curvature?	Yes	◯	No	◯
Details, if yes:				
Is the spinal curvature correctable?				
Are there any limitations in range of movement at hips?	Yes	◯	No	◯
Details, if yes:				
Are there any limitations in range of movement at knees?	Yes	◯	No	◯
Details, if yes:				
Provide details of any previous or planned surgery *(spinal, hip, or lower limb surgery)*				
Provide details of orthoses and any tolerance issues or advice about their use				

Physical measurements

Please record these measurements (if possible)



Key	Measurement	
	cms	inches
A – Width across hips or widest point	_____	_____
B – From back to behind knee	_____	_____
C – From behind knee to base of heel	_____	_____

Height		**feet**		**inches**	***OR***		**metres**
Weight		**stones**		**lbs**	***OR***		**kg**

Equipment type

What type of mobility equipment does this referral relate to?

REMEMBER TO CHECK ELIGIBILITY CRITERIA BEFORE SUBMITTING A REFERRAL FOR A POWERED WHEELCHAIR

Is this referral for a cushion or postural support only?	Yes	☐	No	☐

Details of current mobility equipment *(if applicable):* Wheelchair model and size, cushion/seating type

Usage

What is the current/anticipated frequency of use?	

Location(s) of use (pick all that apply):

Indoors at home or place of residence	☐
Outdoors within garden or grounds of home	☐
Within the classroom and around school or college	☐
Longer distances only (not used within the classroom) at school or college	☐
Within an alternative location e.g. Day Centre	☐
Within the work place	☐
Longer distances outside of home	☐

Priority of referral			
Reason for referral (pick all that apply)			
Change in mobility needs	☐	Difficulty with self-propelling	☐
Change in postural needs	☐	To consider powered mobility	☐
Change in pressure needs	☐	Difficulty using powered controls	☐
Significant increase in height	☐	Change in carer needs	☐
Significant increase or decrease in weight	☐	Change in transport needs	☐
To consider manual self-propelling	☐	Change in home, school, or Day Centre / work environment affecting wheelchair use	☐
Any other details			

Pressure risk				
Does the service user have a life expectancy of less than 6 months?	Yes	◯	No	◯
Is the wheelchair required to enable independent mobility within the home following hospital discharge?	Yes	◯	No	◯
If yes, please provide expected date of discharge:				
Has the wheelchair been involved in an accident and is unusable?	Yes	◯	No	◯
Does use of the current wheelchair present an acute safety risk? *(e.g. because of postural change or change in size)*	Yes	◯	No	◯

Personal Wheelchair Budget (PWB) / Integrated/joint working				
Have you explained the PWB options?				
Has PWB information been shared with the service user?				
Is there interest in a Personal Wheelchair Budget (PWB)? *(Conditions apply)*				
Which option has the service user chosen?				
Is the wheelchair critical for discharge? *(if yes and the service user wants to consider a PWB option other than the Notional NHS, contact the service)*	Yes	◯	No	◯
Are joint funding options for this service user being requested?				
Details of funding options:				
Please give details of anything the service user would like us to know about them or anything they want to achieve with their wheelchair. *Include the WATCh Ad questionnaire, if possible*				

Use of wheelchair for residents of residential or care homes							
If this referral is for attendant-assisted mobility, the service user must require significant postural support and must need to move around the home or be taken out regularly.							
Who will be assisting the service user with using the supportive mobility equipment?							
Name		**Relationship/role**					
Same address as Next of Kin? Yes ◯ No ◯							
Address Line 1							
Address Line 2							
Address Line 3							
Town							
County		**Postcode**					
Telephone number							
Email address							
Will this person be able to attend wheelchair service appointments?	Yes ◯	No ◯					
Appointment information							
Please give details of any barriers to the service user attending the Wheelchair Service Centre:							
Do you wish to attend the appointment?	Yes ◯	No ◯					
Do you wish to be linked in via video?	Yes ◯	No ◯					
Please give details of anyone else who should be invited to the appointment							
Referrer details							
Print name		**Referrer ID**					
Designation		**Contact telephone no.**					
Team/service							
Address							
Email							
Signature							
Is this referral for a powered wheelchair?	Yes ◯	No ◯					
If this is a referral for a powered wheelchair, the referrer should check the eligibility criteria for EPIC and/or EPIOC wheelchairs before submitting							
Is this referral for an attendant-propelled manual wheelchair for a service user residing in a care home?	Yes ◯	No ◯					

Send to Mansfield Wheelchair Service

Reset Form