**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.**

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| **Consent:** |
| Has the client given consent for this referral? | [ ]  Yes  | [ ]  No  |

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| **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:  |

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| GP Name: | Practice: |
| Address:  |
| Post Code: | Telephone No: |
| Is the Service User under Continuing Healthcare? | [ ]  Yes  | [ ]  No  |
| Additional Information relating to Continuing Healthcare? |

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| 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 |

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| **Ethnicity**  |
| Please indicate your ethnic background by ticking**🗹**. (or clicking ) one boxbelow 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 **[ ]** OtherBlack 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)** |

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| 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? |

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| Medical Conditions / diagnosis (including mental health):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Height (estimate) | Weight (estimate) |
| Reason for referral / re-referral: |

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| **All wheelchair and seating clinics are primarily held at the Wheelchair Service premises.**Limited resources are available to provide transport |
| Is the client is medically unfit to travel? | [ ]  Yes | [ ]  No |
| If yes, explain why:  |
| Is the client dependent on use of supplementary oxygen? | [ ]  Yes | [ ]  No |

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| **Wheelchair Requirement** |
| **Does the client have a wheelchair?** | [ ]  Yes | [ ]  No |
| If yes, who supplied it and what wheelchair 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: |
|  | Are they in good health? | [ ]  Yes | [ ]  No |
|  | Please describe their health if you have answered no to the above question: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  Buggy (for children aged 30 months – 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)*  |
| **What mode of transport does the client use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Does the client have adequate boot space for a wheelchair, if they have access to a vehicle?****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Will the client travel in the wheelchair?**  | [ ]  Yes | [ ]  No |
| **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 |
| **Wheelchair delivery-** please let us know where you’d like the equipment to be delivered.(please provide full address) |
|  | Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **This section is compulsory for Health Professionals to complete****\*Non - professionals please complete to your best ability** |
| Is the wheelchair essential for discharge? | [ ]  N/A | [ ]  No  | [ ]  Yes Discharge date: |
| *(Essential for discharge is where provision will enable the person to be independent of carers)* |
| Is the client’s condition: | [ ]  Stable | [ ]  Deteriorating | [ ]  Rapidly deteriorating |
| [ ]  Terminal Condition | [ ]  Epilepsy | If yes, when was the last seizure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Allergies: [ ]  No [ ]  Yes Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cognition:  |
| Vision:  |
| Surgery (past/planned):  |
| History of falls:  |
| Pressure area (grade/location):  |
| Sitting balance: | [ ]  Independent | [ ]  Short periods | [ ]  With assistance of  |
| **Posture (if you are able to fill in the information below, please do to the best of you knowledge):** |
| 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: |  |  |
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| Any other alerts (behaviour, substance use, MRSA, etc.)?  |

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| **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 assessmentAre you a trusted prescriber? Yes [ ]  No [ ]  If yes, please state your Prescriber No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signed: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| **This section if for Accredited Prescribers** |
| **Measurements** (body dimensions)  | **Note** – measure in sitting using a straight or rigid tape measure  |
|  | Height (\*essential) |
| Weight (\*essential)  |
| A – Hip width |
| B – Upper leg length (L) (R)  |
| C – Lower leg length (L) (R)  |
| D – Height of scapular (inferior angle) (Not necessary) |
| E – Elbow height (Not necessary) (L) (R)  |
| Other: |

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| **Model of Wheelchair Required?** |
| Attendant Propelled? | [ ]  Yes | [ ]  No |
| Self Propelled? | [ ]  Yes | [ ]  No |
| Has the client trialled the wheelchair? | [ ]  Yes | [ ]  No |

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| **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?  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Lap belt?** |
| Does the client require a lap belt? | [ ]  Yes | [ ]  No |
| Has the Client given consent? | [ ]  Yes | [ ]  No |
| **If the client is unable to consent has a best** **interest decision been made?** |  [ ]  Yes | [ ]  No |

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| **Accessories?** |
| Does the client require any accessories?  | [ ]  Yes | [ ]  No |
| Please state what is required? | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Anti-Tippers required? | [ ]  Yes | [ ]  No |

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| **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 |

***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 the relevant section 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 sent 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

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| **How to refer - DSX** |

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| * 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.
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**If you have any queries completing this form please call 020 8664 8860 (Option 1)**

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| **Please return this form to:****CES Croydon Wheelchair Service****CLIC****3 Imperial Way****Croydon****CR0 4RR****Tel: 020 8664 8860 (Option 1)****Email:** **ceswheelchairs@nhs.net** **cesadmin@croydon.gov.uk** |