**Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **This form must be completed by a Healthcare Professional; missing information will lead to delays in provision. Please return this form using the details at the bottom of the page.** **MKWCS can only supply wheelchairs to people where the wheelchair will be the primary means of mobility INDOORS.** | **For office use only**BEST ID: | Date stamp: |  |
| New [ ]  | Existing [ ]  |  |

**Patient details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient’s first name:** |  | **NHS number:** |  |
| **Patient’s surname:** |  | **Title:** | Mr | Mrs | Miss | Ms | Dr | Other |
|  |  |  |[ ] [ ] [ ] [ ] [ ]   |
| **Date of birth:** |  | **Ethnic group:** |  |
| **Care needs:** | Low | Medium | High | Specialist | **This individual represents a safety concern for lone workers**[ ]  **Yes:** |
|  |[ ] [ ] [ ] [ ]   |
| **Address (including postcode):** |  | **Main contact (if not patient):** |  |
| **Telephone number:** |  | **Funding source:** | ☐ Local healthcare funding |
| **Mobile number:** |  |  | ☐ Continuing Healthcare |
| **Email:** |  |  | ☐ Other: |
| **Communication issues:** | None [ ]  | Non-verbal [ ]  | Non-communicative [ ]  | Interpreter required [ ]  |
| **Height:** |  | **Diagnosis:** |  |
| **Weight:** |  |  |  |
| **Hip width:** |  |  |  |
| **Seat depth:** |  |  |  |
| **Knee to heel length:** |  | **Considered to have a terminal illness (ie <6 months)** | ☐ |
| **Able to self-propel?** | [ ]  Yes | **Known to the Specialist Palliative Care Team or has a DS1500 (or equivalent) form:** | ☐ |
|  | [ ]  No |  |  |
| **Walking ability:** | [ ]  Unable to walk | **Considerations for seating provision:** | **Contractures which would prevent normal sitting** | Hip | Knee | Ankle |
| **Recent history of falls?** | [ ]  | [ ]  With equipment indoors |  |  | [ ]  | [ ]  | [ ]  |
|  |  | [ ]  Independent | **Distance:** |  |  | [ ]  Specialist controls | [ ]  PEG  |
| **Sitting balance:** | [ ]  Needs support |  | [ ]  On-chair AAC | [ ]  Ventilated/oxygen |
|  | [ ]  Able to sit unaided |  | **Continence issues** | [ ]  Catheter  |
| **Transfer ability:** | [ ]  Hoist |  | Bladder [ ]  | Bowels [ ]  | [ ]  Suprapubic catheter  |
| **Hoist type:** |  | [ ]  With assistance |  |  |  | [ ]  Pads |
|  |  | [ ]  Independent  |  | Scoliosis | Mild | Mod | Sev |
| **How often will the wheelchair be used?** | [ ]  Daily |  |  | [ ]  | [ ]  | [ ]  |
|  |  |  | Kyphosis | [ ]  | [ ]  | [ ]  |
|  | [ ]  More than once a week |  | Pelvic obliquity | [ ]  | [ ]  | [ ]  |
|  | [ ]  Once a week or less |  | Spasticity | [ ]  | [ ]  | [ ]  |
| **Where will the wheelchair be used most often?** | [ ]  Indoors |  | ↑Tone | [ ]  | [ ]  | [ ]  |
|  | [ ]  Indoors and outdoors |  | ↓Tone | [ ]  | [ ]  | [ ]  |
|  | [ ]  Outdoors |  | ↑Foot deformity | [ ]  | [ ]  | [ ]  |
| **How long will the patient be seated in the chair during the day?** | <2hr | 2-4hr | 4-8hr | >8hr | **Current wheelchair (if applicable):** |  |
|  |[ ] [ ] [ ] [ ]   |  |
| **Is it likely that review by Community Occupational Therapy will be required for home adaptations?** | [ ]  Not required/already adapted | **Current seating system (if applicable):** |  |
|  | [ ]  I have already referred to this service |  |  |
|  | [ ]  I will be referring to this service |  |  |

**Please could you see this person for:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ASSESSMENT:** | **Manual wheelchair:** | ☐Self-propelled | ***Powered wheelchair:*** | ☐Indoors only |
|  |  | ☐Attendant propelled |  | ☐Indoor and outdoor |
|  |  | ☐ Tilt in space |  | ☐ Specialist controls |
|  |  | ☐Pressure relieving seating |  | ☐Pressure relieving seating |
|  |  | ☐Specialist seating |  | ☐Specialist seating |
| **REVIEW:** | ☐Chair uncomfortable | ☐Chair outgrown | **Other:**  |  |
|  | ☐Change in needs | ☐Pressure ulcers |  |  |
|  | ☐Specialist controls | ☐Specialist seating |  |  |
| **Please provide any additional details about this person or their needs** (Please also include any information relating to any safety concerns for lone workers if this has been raised as an issue)**:** |
|  |
|  |
| **PRESSURE ULCER RISK ASSESSMENT – BRADEN SCALE****Patients with existing or previous pressure damage are immediately high risk** |
| **Sensory perception** – *ability to respond meaningfully to pressure related discomfort* | **Mobility** – *ability to change and control body position* | **Moisture** – *degree to which skin is exposed to moisture* |
| 1. Completely Limited |[ ]  1. Completely immobile |[ ]  1. Constantly moist |[ ]
| 2. Very Limited |[ ]  2. Very Limited |[ ]  2. Very moist |[ ]
| 3. Slightly Limited |[ ]  3. Slightly Limited |[ ]  3. Occasionally moist |[ ]
| 4. No impairment |[ ]  4. No limitations |[ ]  4. Rarely moist |[ ]
|  |
| **Activity** – *degree of physical activity* | **Nutrition** – *Usual food intake* | **Friction and Shear** |  |
| 1. Bed bound |[ ]  1. Very poor |[ ]  1. Problem |[ ]
| 2. Chair bound |[ ]  2. Probably inadequate |[ ]  2. Potential problem |[ ]
| 3. Walks Occasionally |[ ]  3. Adequate |[ ]  3. No apparent problem |[ ]
| 4. Walks frequently |[ ]  4. Excellent |[ ]   |  |
| Existing or previous pressure damage: | [ ]  - *High Risk* | Total Score |  |
| Location and grade of previous pressure ulcer(s): |  | 16+ = Low risk13 – 15 = Medium riskLess than 12 = High risk |[ ]
|  |  |  |[ ]
|  |  |  |[ ]

To be used in conjunction with clinical judgement. Please note lower scores indicate a higher risk of pressure ulcer development.

Information on other Risk Factors which would indicate a requirement for pressure management (E.g. sitting posture, transfer technique, etc):

|  |
| --- |
|  |

**GP details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Email:** |  |
| **Surgery and address (including postcode):** |  | **Telephone number:** |  |
| **Fax number:** |  |

**By placing this referral I acknowledge that this individual is either unable to, or is unsafe mobilising without a wheelchair, and that a wheelchair would be their primary means of mobility indoors, within their home.**

**Referrer details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Email:** |  |
| **Profession:** |  | **Telephone number:** |  |
| **Address (including postcode):** |  | **Accreditation number (where applicable):** |  |
| **I would like to be invited to any appointments that are made:** | [ ]  | **Signature:** |  |
| **I have obtained the patient’s consent to refer to MKWCS:** [ ] **OR – I am acting in their best interests by referring:** [ ]  | **Date form completed:** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Milton Keynes Wheelchair Service Professional Referral Form | DocID: | Version | Created by: | Created on: | Last review: | Last review by: | Due for review:  |
| 3.4 | N. Robson | 05/2016 | 12/2016 | N. Robson | 12/2017 |