

Hull and East Riding of Yorkshire Wheelchair Service Referral Form

This form is to be completed by a registered health or social care professional. Please ensure you have read the eligibility criteria, available here: <https://www.ajmhealthcare.com/local-service-centres/hull-and-east-riding/>

Please complete the form in full. Mandatory fields are marked in red. Incomplete forms may be returned to you and may cause delays. This form is designed for completion on-screen. We recommend using Adobe Acrobat software.

For assistance with this form, please call the wheelchair service on 0808 175 3969. When complete, please return your referral form using a secure email service to ajm.ery-hullwheelchairservice@nhs.net.

01. Prioritisation Information

Is the service user receiving palliative care?	Yes	No	Discharge date:
Are there current grade 3/4 pressure injuries?	Yes	No	Discharging from hospital/ward:
Is this referral required for hospital discharge?	Yes	No	Discharging to:

02. Service User Details

Title:	Does the service user have capacity?	Yes	No			
Forename(s):	If no, who will act in their best interests?					
Surname:	Relationship:					
Telephone/mobile:	Telephone/mobile:					
Email:	Email:					
Address, including postcode:	Address, including postcode:					
Are there any risks to staff visiting the address?	Yes	No	Is this person a "Looked After Child"?	Yes	No	
If yes, details:	If yes, details/funding:					
Date of birth:	Is this person CHC or CC funded?				Yes	No
NHS Number:	If yes, details/funding:					
Any religion/belief:	Is this person a prisoner?				Yes	No
Ethnicity:	If yes, details/funding:					
Communication needs:						

03. GP Details

GP Name:	Address, including postcode:
Telephone:	
Email:	

04. Reason for Referral

Option 1. Please assess this person.

They require:

Option 2. This person is an existing wheelchair service user. Please review their existing provision.

The main reason for review is:

Option 3. Please assess this person for a powered wheelchair. I confirm I have read the eligibility criteria for powered wheelchair provision.

They require:

Can they safely and effectively self-propel a manual wheelchair indoors? Yes No

Do they have any visual impairments which would affect their ability to safely drive a powered wheelchair? Yes No

Do they have any cognitive or visuo-spatial issues, or suffer from hearing impairment, epilepsy or any other conditions which can cause loss of consciousness? Yes No

If you have answered yes to any of these questions, please provide details in the space below.

Option 4. I am a Wheelchair Approved Prescribed (WAP) or an Advanced Wheelchair Approved Prescriber (AWAP) and I will complete the Prescription Request section at the end of this form.

Please provide any further details about your reason for referring this person here:

05. Existing Care Arrangements

Formal carers

Service name:

Frequency of care:

Contact details:

Contact name:

Occupational Therapy

Service name:

Contact details:

Contact name:

Physiotherapy

Service name:

Contact details:

Contact name:

Education/Work

Service name:

Contact details:

Contact name:

Informal carers

Name/details:

Frequency of care:

Contact details:

Contact name:

Social care

Service name:

Contact details:

Contact name:

Speech and Language Therapy

Service name:

Contact details:

Contact name:

Any other relevant organisation

Service name:

Contact details:

Contact name:

06. Medical Details

Height:	Can the person self-propel?	Yes	No
Weight:	Is there a recent history of falls?	Yes	No
Diagnosis / medical condition / reason for referral:	Is this person considered to have a terminal illness (i.e. <6 months)?	Yes	No
	Are they known to a palliative care team or do they have a DS1500 (or equivalent) form?	Yes	No

What is their mobility status?

How long are they able to maintain a sitting balance unaided?

How often will the wheelchair be used?

How long will they be seated in the chair each day?

Where will the wheelchair be used most often?

How do they transfer / what is their transfer ability?

What wheelchair do they currently use, if any?

What cushion/seating system do they currently use, if any?

Hip width:

- The width of the widest part of the hip
- Ensure that the tape measure does not bend when measuring

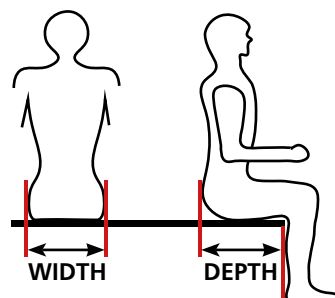
Seat depth:

- From the back of the knees to the rear-most part of the bottom

Knee to heel length:

- From the back of the knee to the floor, under the heel

Measurement Guide



Are there any considerations for seating provision? For completion by medical professionals. Please leave blank if unknown.

Specialist controls may be required	Contractures preventing normal sitting	Hip	Knee	Ankle
Use of PEG feeding tube	Scoliosis	Mild	Moderate	Severe
Augmentative/Alternative Communication (AAC) needs	Kyphosis	Mild	Moderate	Severe
Use of ventilator or oxygen	Pelvic obliquity	Mild	Moderate	Severe
Continence issues with bladder	Spasticity	Mild	Moderate	Severe
Continence issues with bowels	Increased tone	Mild	Moderate	Severe
Use of a catheter	Decreased tone	Mild	Moderate	Severe
Use of a suprapubic catheter	Increased foot deformity	Mild	Moderate	Severe
Use of incontinence products, e.g. absorbent pads				

Please provide any additional details about the person or their needs. If none, please state "n/a".

09. Referrer Details

Name:	Email:
Profession / role:	Telephone:
Address:	Accreditation number:
	I have obtained this person's consent for this referral:
	OR I am acting in this person's best interests by referring:
Signature:	I would like to be invited to any appointments made:
<small>If completing on-screen, please write your name in this box and send from your personal email.</small>	Date:

10. Approved Prescriber Prescription Request

This section should only be completed by those who have attended the Wheelchair Approved Prescriber (WAP) or Advanced Wheelchair Approved Prescriber (AWAP) training provided by the wheelchair service. All other referrers should leave this section blank. If you are interested in becoming a WAP/AWAP, please contact us as above.

WAP/AWAP Number:	I confirm this request meets the service eligibility criteria:
I confirm I have informed this person about their legal right to a Personal Wheelchair Budget:	This person has requested a PWB assessment:

Please select the type of wheelchair required:

- Option 1.** Please provide a manual self-propel wheelchair.
- Suitable for adults up to 133kg (21 stones) in weight
 - The wheelchair will weigh approximately 18 kilograms (38 pounds), excluding any accessories chosen
 - The user should not have any medical contraindications
- Option 2.** Please provide a manual attendant propel wheelchair.
- Suitable for adults up to 133kg (21 stones) in weight
 - The wheelchair will weigh approximately 15 kilograms (34 pounds), excluding any accessories chosen
- Option 3.** Please provide a tilt-in-space wheelchair.
- This option is only available for Advanced Wheelchair Approved Prescribers (AWAP)**

Please select the dimensions and any additional accessories required below. Wheelchairs are provided with a 2" cushion as standard. If you select a specialist cushion, please ensure you have completed the Pressure Ulcer Risk Assessment section above.

Size required:			Specialist cushion:		
Elevating leg rest (left):	Yes	No	Stump board (left):	Yes	No
Elevating leg rest (right):	Yes	No	Stump board (right):	Yes	No
Oxygen carrier:	Yes	No	Anti-tipper (left and right)	Yes	No
Vent / equipment tray:	Yes	No	Headrest:	Yes	No
Other equipment:					

Please state why the equipment is required, ticking all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Hospital discharge short term loan | <input type="checkbox"/> Work or education |
| <input type="checkbox"/> Attending GP/hospital appointments | <input type="checkbox"/> Outdoor leisure |
| <input type="checkbox"/> Personal care | <input type="checkbox"/> Attending day centre(s) |
| <input type="checkbox"/> Mobility in the home | <input type="checkbox"/> Other: |

Thank you for completing the referral form. If you would like to provide feedback on this form, or any other aspect of the wheelchair service, please email ajm.ery-hullwheelchairservices@nhs.net. Your feedback is important to us.