**Referral Form**

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| --- | --- | --- | --- | --- |
| **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:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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)**:** | | | | | | | | | | | | |
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|  | | | | | | | | | | | | |
| **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 risk  13 – 15 = Medium risk  Less than 12 = High risk | |  |
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|  |

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):

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**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:** |  |

|  |  |  |  |  |  |  |  |
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| 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 |