Powered Wheelchair Referral Form

REWS (Rotherham Equipment & Wheelchair Service)

This form should be completed and signed by the patient’s Doctor **AND** Healthcare Professional

**Please complete ALL sections fully. Failure to do so will result in delays processing the request.**

Please note we do not provide scooters.

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| **Patient’s Personal Details** |
| Title |        | Gender | Male [ ]  Female [ ]  |
| Surname |       |  |  |
| Forename(s) |       | Date of Birth |       |
| Preferred Name |       | NHS Number |       |
| Home Address |       | Delivery Address |       |
|  |  |  |  |
| Post Code |       | Post Code |       |
| Tel No. |       | Contact |       |
| Mobile No. |       | Tel No. |       |
| Email Address |       | Main Language |       |
| Ethnic Origin |       | Religion |       |
| Disability |       |
| Relevant Medical Details |       |
| Critical Case (e.g. terminal illness) Yes [ ]  No [ ]  |
| Essential for hospital discharge? Yes [ ]  No [ ]  Date       |
| Is this person already in possession of an NHS wheelchair? Yes [ ]  No [ ]  |

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| **Details of GP** |
| Name |       | Address |       |
| Tel No. |       |  |
| CCG |       | Post Code |       |

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| **Details of Prescriber** |
| Print Name |       | Address |       |
| Tel No. |       |  |
| Profession |       | Post Code |       |
| Would you like to be present at the assessment? Yes [ ]  No [ ]  |
| Signature |  | Date |       |

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| **Assessment Details: Wheelchair** |
| What is the person’s walking ability within the home?  |  |
| What is the person’s transfer method? |        |
| How often will the wheelchair be used? |  |

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| **Assessment Details: Cushion** |
| Is a standard foam cushion adequate?  | Yes [ ]  No [ ]  If yes:  |
| Suggested cushion? |       |
| What is the maximum duration the personwill sit in the wheelchair in one session? |  |
| Can the person maintain sitting balance in the wheelchair? | Yes [ ]  No [ ]  |
| Person’s tissue status: |
| Previous sore(s): Yes [ ]  No [ ]  | Present sore(s): Yes [ ]  No [ ]  |
| Site       Grade       | Site       Grade       |
| Continence status: |  |
| Who will maintain and monitor cushion?  |       Waterlow score       |

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| **Assessment for Powered Wheelchair** |
| Assessment required for indoor powered wheelchair? | Yes [ ]  No [ ]   |
| Assessment required for indoor/outdoor powered wheelchair? | Yes [ ]  No [ ]  |
| Accessories required: |       |



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| **Measurements** |
| Height |       |
| Weight |       |
| A = Hip width |       cms      ins |
| B = Back of buttocksto back of knee |       cms      ins |
| C = Back of knee to soleof foot |       cms      ins |
| D = Seat to top of head |       cms      ins |

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| **Further Assessment by REWS Centre Team Will Be Required** |
| Is further assessment required by REWS? | Yes [ ]  No [ ]  | **Interested in Personal Wheelchair Budget?** | Yes [ ]  No [ ]  |
| Referrer would like to be present at assessment? | Yes [ ]  No [ ]  |
| Referr’s Comments |       |

**Please Forward to Patient’s Doctor Before Submitting to REWS**

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| **Section for Doctor to Complete** |
| Please complete the request for medical information, which is needed before an assessment can be arranged for a powered wheelchair for your patient.Please tick the selected answer. |
| **1. Mobility:** In your opinion, is this person unable to walk or self propela manual wheelchair, or are they medically at risk to do so?Comments:?       | Yes [ ]  No [ ]  |
| **2.** Is this patient affected by the following?: **A. Epilepsy/blackouts** Has the patient had a seizure in the past year? **B. Any medication or their side effects:**Comments:?      **C. Visual impairments** Please give details:      **D. Mental health problems (relevant to safe wheelchair use)** Comments:?      **E. Perceptual deficits e.g. neglect** **F. Any other conditions that may affect safe use of a powered chair?** Comments:?       | Yes [ ]  No [ ] Yes [ ]  No [ ] Yes [ ]  No [ ] Yes [ ]  No [ ] Yes [ ]  No [ ] Yes [ ]  No [ ] Yes [ ]  No [ ]  |
| **3.** In my opinion, this individual is medically fit to control an EPIC(Electrically Powered Indoor wheelchair) | Yes [ ]  No [ ]  |
| Doctor’s Signature |  | Print Name |  |
| Date |       |  |  |

**PLEASE RETURN TO:**

Rotherham Equipment Wheelchair Service
Eastwood Trading Estate
Chesterton Road
Rotherham
S65 1SX

Tel: 01709 916889

Fax: 01709 263296

Email: cabsl.rotherhamwheelchairservices@nhs.net