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 | | | |

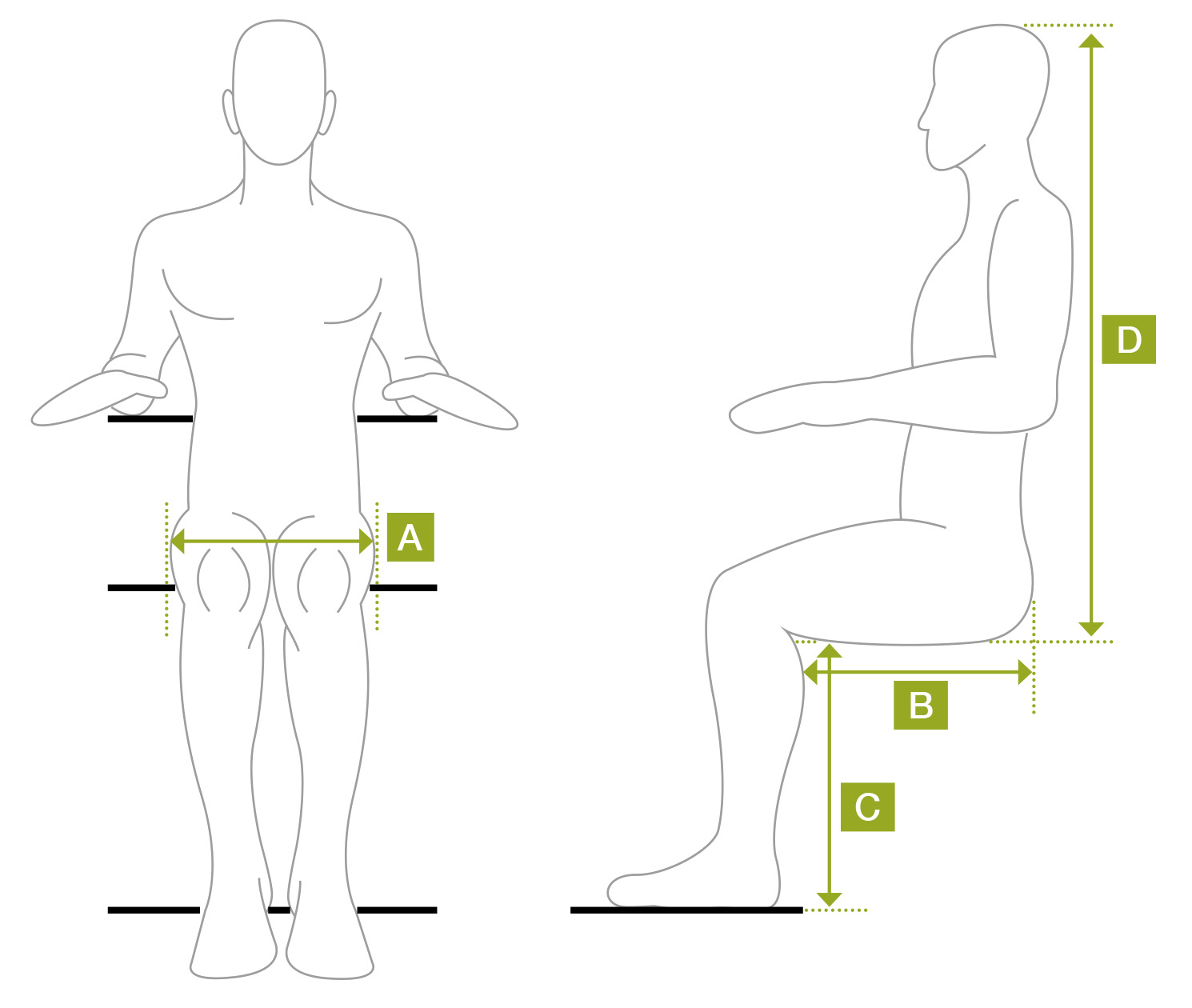
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| --- | --- | --- | --- |
| **Details of GP** | | | |
| Name |  | Address |  |
| Tel No. |  |  |
| CCG |  | Post Code |  |

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

|  |  |
| --- | --- |
| **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 person will 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 |

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



|  |  |
| --- | --- |
| **Measurements** | |
| Height |  |
| Weight |  |
| A = Hip width | cms        ins |
| B = Back of buttocks to back of knee | cms        ins |
| C = Back of knee to sole of 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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 propel a 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](mailto:cabsl.rotherhamwheelchairservices@nhs.net)