Manual Wheelchair & Specialist Buggy Referral Form

REWS (Rotherham Equipment & Wheelchair Service)

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

(For persons with terminal illness or long-term disability of 6 months or longer.)

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

For Powered Chairs Please Complete Powered Wheelchair Referral Form.

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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 |       |
|  |  |  |  |
| **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? |  |
| Does the person need to sit in the wheelchair when travelling in transport | Yes [ ]  No [ ]  |

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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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| **Type Required** |
| **Non-Powered Wheelchair:** Person has limited walking ability, likely to be in excess of six months or is terminally ill. |
| Self Propelling |        | Attendant Push Chair |        |



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| **Measurements** |
| Height |       |
| Weight |       |
| A = Hip width |       cms960413 Iss1 Online – Manual & Specialist      ins |
| B = Back of buttocksto back of knee |       cms      ins |
| C = Back of knee tosole of foot |       cms      ins |
| D = Seat to top of head |       cms      ins |

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| **Further Assessment by REWS** |
| 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 [ ]  |

**For Powered Chairs Please Complete Powered Wheelchair Referral Forms in Conjunction With Therapist or Specialist Nurse. We Do Not Provide Scooters or Powered Chairs For Outdoor Use Only.**

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| **Other Relevant Information To Support Your Assessment(e.g. Posture, Home Environment, Carer Details)** |
|       |

**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