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.

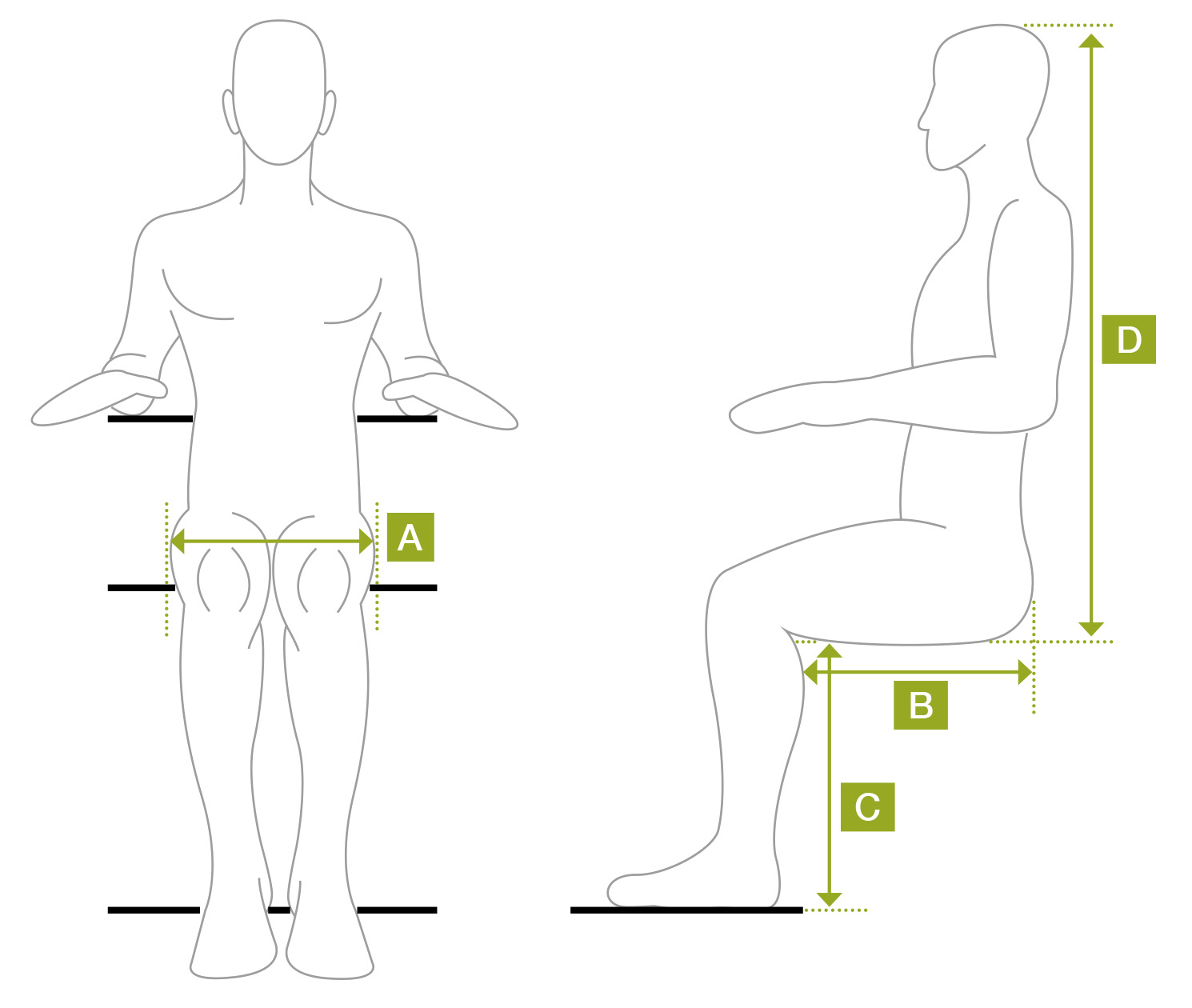
|  |  |  |  |
| --- | --- | --- | --- |
| **Patient’s Personal Details** | | | |
| Title |  | Gender | Male  Female |
| Surname |  |  |  |
| Forename(s) |  | Date of Birth |  |
| Preferred Name |  | NHS Number |  |
| Home Address |  | Delivery Address |  |
|  |  |  |  |
| Post Code |  | Post Code |  |
| 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 | | | |

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

|  |  |
| --- | --- |
| **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 |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |



|  |  |
| --- | --- |
| **Measurements** | |
| Height |  |
| Weight |  |
| A = Hip width | cms  960413 Iss1 Online – Manual & Specialist        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 |

|  |  |  |  |
| --- | --- | --- | --- |
| **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.**

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