NHS
Bristol Centre for Enablement

Powered Wheelchair Referral Form

CONFIDENTIAL

Contact Details:

Wheelchair & Special Seating Services
Highwood Pavilions
Jupiter Road
Patchway, Bristol
BS34 5BW
Tel: 0117 414 4900
Fax: 0117 340 3454

Instructions:

- This form should be used when a client requires a powered wheelchair because of a permanent illness or disability (Permanent is defined as 6 months or more).
- **This form should ONLY be completed by clients GP or another health care professional who has completed the Wheelchair Service accredited referrer course.** (For information on how to become an accredited referrer, please contact the wheelchair service)
- **Sections must be completed where specified. Incomplete, unsigned and/or undated referral forms will be returned.**
- Further information, referral forms and criteria for issue can be found on our website: Bristol Centre for Enablement

Client Details This section must be fully completed)

Surname	**NHS Number**
Title	**Forenames**
Address	**Telephone (Home)**
	Telephone (Work/Mobile)
Post Code	
Email address:	**Ethnic Origin**

Address Type :	**Private Address**		**Nursing Home**		**Residential Home**	

Date of Birth		**Height**		**Weight**	

Referrer Details & GP Details
(This section must be fully completed)

Referrer		**Profession**	
Address		**Telephone**	
		Fax	
Post Code			
Email address:			
General Practitioner			
Practice		**Telephone**	
		Fax	
Post Code			

BCE Staff Use Only:

BDSC Number Allocated :	**Received Stamp :**
Date:	

Medical History
(Diagnosis and Fitness to Self Propel must be completed)

Diagnosis and Prognosis (Please Print Clearly)

Is client medically fit to self-propel a wheelchair?	**YES**		**NO**		**Short Supervised Distances Only**	

Current Level of Mobility:

Walking: (please give details walking aids, any falls etc.)

Wheelchair: (type self-propel, attendant, indoor ability to self-propel)

Transfers:

Other Relevant Information:

Vision	
Epilepsy, Vacant Episodes	**Date of last seizure if known (NB individuals must be a minimum 12 months seizure free to be permitted to drive powered equipment outdoors)**

Weight Trend : **Stable** ☐ **Increasing** ☐ **Decreasing** ☐ **Fluctuating** ☐

Wheelchair Use (This section must be fully completed)

Term of Use : **Less than 6 months** ☐ **More than 6 months** ☐

Days use per week : **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

Period sat in wheelchair (on average): **Less than 2 hours** ☐ **2 to 8 hours** ☐ **More than 8 hours** ☐

Type of Use : **Indoors Only** ☐ **Indoors and outdoors** ☐

Carer Details

Named Carer		**Relationship**	

Address	**Telephone**
	Post Code

Other Healthcare Professionals involved (Consultant, PT, OT, Prosthetist, District Nurse, Health visitor, etc.)
Please give names and contact numbers :
Other organisations involved (Day centre, school, workplace, nursery, charities etc.)

Home and Local Environment

Please give details of any factors that need to be considered re: home environment i.e. size constraints, narrow doors, lift access etc.)

Please Select Applicable Information Below **(relevant for indoor and outdoor equipment request)**

Property Access Level	**YES ☐**	**NO ☐**	
Property Access Ramped	**YES ☐**	**NO ☐**	**Awaiting ☐**

Local Environment	**Local Amenities ☐ i.e. shops**	**Pavements ☐**	**Dropped Kerbs ☐**
	Hilly ☐	**Busy Roads ☐**	**Rural ☐**
Transport	**WAV ☐**	**None ☐**	**Other ☐ Please State:**

Any Other Relevant Information (e.g. use of Communication Aids):

Powered Wheelchair Requirements (Option 1 or 2 must be completed)

1	**Further Assessment for INDOOR ONLY Powered Wheelchair**	
2	**Further Assessment for Electrically Powered Indoor AND Outdoor Powered Wheelchair**	

Referrers Signature (This section must be fully completed)

I, the referrer, confirm that the information supplied with this form is correct to the best of my knowledge.

I have read and understood the criteria for powered equipment provision

I have gained consent from the client to complete this referral form.

Referrers Signature		**Date**		**Accreditation Number**				

Thank you for completing this form