

**Wheelchair & Special Seating Service – GP Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | | | | | | | | | | | | | | | | **GP Details** | | | | | | | | | | | | | | | | | | | |
| NHS Number |  | | | | | | | | | | | | | | | | | | | GP Name | | | | | | | | | | | | |  | | | | | | |
| Title |  | | | | | | | | | | | | | | | | | | | Nat GP Code | | | | | | | | | | | | |  | | | | | | |
| Forename |  | | | | | | | | | | | | | | | | | | | Telephone No | | | | | | | | | | | | |  | | | | | | |
| Surname |  | | | | | | | | | | | | | | | | | | | Surgery Name | | | | | | | | | | | | |  | | | | | | |
| DOB | (DD/MM/YYYY) | | | | | | | | | | | | | | | | | | | Surgery Address  & Postcode | | | | | | | | | | | | |  | | | | | | |
| Gender |  | | | | | | | | | | | | | | | | | | |
| Address Type | Private | |  | | | | | Nursing Home | | | | | | | |  | | | | Residential Home | | | | | | | | | | | | |  |  | | | | | |
| House Name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address 1 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address 2 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Town |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| County |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postcode |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone No |  | | | | | | | | | | | | | Mobile No | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Other Tel |  | | | | | | | | | | | | | Other Tel Description | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Ethnicity |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Interpreter Required | | Yes | | | | |  | | | | No | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
| Preferred Language | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical Conditions** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Diagnosis | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Secondary Diagnosis | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional Medical Information | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Infection Diagnosis  If yes, please specify | | | | | | | | | Yes | | | |  | | | | No | | | | | | | |  | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mobility Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Walking Ability | | | | | None | | | | | | |  | | | Indoors Only | | | | | | | | | | | | | | |  | | Short Distances Only | | | | | | |  | |
| Fit to Self-Propel Wheelchair | | | | | Yes | | | | | | |  | | | No | | | | | | | | | | | | | | |  | |  | | | | | | | |
| Ability to transfer | | | | | Independent | | | | | | | | | |  | | | Hoist | | | | | | | | |  | | | Other | | | | | | | | |  |
| **Wheelchair Use** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Duration of Use | | | | Less than 6 months | | | | | | | | | | | | | | | | | | | |  | | | | More than 6 months | | | | | | | | | | |  | |
| Days per week | | | | 1-3 days | | | | | | | | | | |  | | | | 4-7 days | | | | | | | | | |  | | | Full time user | | | | | | |  |
| Type of use | | | | Indoors only | | | | | | | | | | |  | | | | Outdoors only | | | | | | | | | |  | | | Indoors and Outdoors | | | | | | |  | |
| Below 6 months of use or under 4 days is not sufficient to meet the criteria. If there are exceptional circumstances to be considered then this must be supplied in the additional information section at the end of referral. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physical Measurements** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height | | | | | | | | | | Feet | | | | | | | | | | | | Inches | | | | | | | | | | | | | Metres | | | | | |
| Weight | | | | | | | | | | Stone | | | | | | | | | | | | Lbs | | | | | | | | | | | | | Kilos | | | | | |
| **Wheelchair Type** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Self propelling | | | | | |  | | | | Attendent pushed | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | |
| Due to the patients mobility problems do you feel an assessment is required | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | |  | No |  | | |

Thank you for your referral. Your information will be considered by the clinical team and the referral progressed as appropriate.