

**GP referral for an NHS MANUAL wheelchair from Southern Hampshire**

**Wheelchair Service**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Title** |  | | | | | **Ethnic origin** |  | | | | **Gender** |  | |
| **Surname** |  | | | | | | **First name(s)** | | | |  | | |
| **Date of birth** |  | | | | | | **NHS No** | | | |  | | |
| **Address, inc postcode** |  | | | | | | | | | | | | |
| **Telephone numbers** | (1) | | | | | | | (2) | | | | | |
| **Patient’s e-mail** |  | | | | | | | | | | | | |
| **Next of kin name (NOK)** |  | | | | | | **Relationship** | | | |  | | |
| **NOK Tel No** |  | | | | | | **NOK e-mail** | | | |  | | |
| **HEIGHT (approx)** |  | | | | | | **WEIGHT approx)** | | | |  | | |
| **GP DETAILS** | | | | | | | | | | | | | |
| **GP Name+ Address** |  | | | | | | **GP telephone** | | | |  | | |
| **Surgery code** |  | | | | | | **GP e-mail** | | | |  | | |
| **CONSENT** | | | | | | | | | | | | | |
| **Has your patient consented to this referral?** | | | | | | | | Yes □ No □ | | | | | |
| **If no, who is the advocate for your patient?** | | | | | | | |  | | | | | |
| **RISK / SAFEGUARDING** | | | | | | | | | | | | | |
| **Have you identified any risks for this patient, including safeguarding concerns?** | | | | | | | | Yes □ No □ | | | | | |
| **Is your patient a looked after child?** | | | | | | | | Yes □ No □ | | | | | |
| If yes to either, please give details | | | | | | | | | | | | | |
| **DIAGNOSES (including impact on mobility)** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **REASON FOR REFERRAL AND LEVEL OF MOBILITY (distance, aids used)** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **HOW OFTEN WILL THE WHEELCHAIR BE USED? (Essential, please tick):-**  ***(Please note, if your patient is not in need of a wheelchair at least 4 days a week, they are not eligible for an NHS wheelchair)*** | | | | | | | | | | | | | |
| **Daily** | | **□** | | | **4 days a week or more** | | | | **□** | **Less than 4 days a week** | | | **□** |
| **REQUEST IS FOR (please tick)** | | | | | | | | | | | | | |
| **Self-propelled**  **wheelchair** | | **□** | | **Attendant pushed wheelchair** | | | | □ | | **Unknown** | | | □ |
| If attendant pushed wheelchair, who will be the attendant? | | | | | | | | | | | | | |
| **ANY BARRIERS TO COMMUNICATION? eg. registered blind, dysphasia, non-verbal** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **CURRENT PRESSURE ULCERs?** | | | | | | | | | | | | | |
| **YES** | | | **□** | | **NO** | | | | **□** | **Unknown** | | | **□** |
| If yes, please describe location / grade / know treatment etc | | | | | | | | | | | | | |
| ***Attach a GP medical summary detailing the patients past medical problems with this form*** | | | | | | | | | | | | | |
| **REFERRER’S DETAILS** | | | | | | | | | | | | | |
| **GP name** | |  | | | | | | | | | | | |
| **Date of referral** | |  | | | | | | | | | | | |

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| **PLEASE RETURN THIS COMPLETED FORM TO:-** |
| **SOUTHERN HAMPSHIRE WHEELCHAIR SERVICE**  **Unit E1 Omega Enterprise Park; Chandlers Ford Industrial Estate; Eastleigh; SO53 4SE**  **Telephone: 0333 00 38 071 / Fax: 0333 00 38 073**  **Email: scwcsu.hantswheelchairservice@nhs.net** |