**Referral Form**

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| **This form must be completed by a Healthcare Professional; missing information will lead to delays in provision. Please return this form using the details at the bottom of the page.** **The Wheelchair Service can only supply equipment to people where the wheelchair will be the primary means of mobility INDOORS.** | **Please return forms to:-****AJM Healthcare, Unit C5 Leyton Industrial Village, Argall Avenue, Leyton, London, E10 7QP****EMAIL****:**  walthamforest@ajmhealthcare.org**Tel No: 0808 196 1850 | Fax No: 0808 196 1852** |

**Essential information (please record full details in the relevant section of the referral):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Palliative user** | [ ]  | **Required for discharge** [ ]  | **Date of discharge:** |  | **Height:** |  |
| **Current pressure wound (grade 3-4)** | [ ]  | **Hospital/ward:** |  | **Weight:** |  |

**Please could you see this person for:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ASSESSMENT:** | ***Manual wheelchair or buggy:*** | ☐Self-propelled | ***Powered wheelchair:*** | ☐Indoors only |
| ☐Attendant propelled | ☐Indoor and outdoor |
| ☐ Tilt in space | ☐ Specialist controls |
| ☐Pressure relieving seating | ☐Pressure relieving seating |
| ☐Specialist seating | ☐Specialist seating |
| **REVIEW:** | ☐Chair uncomfortable | ☐Chair outgrown | **Other:**  |  |
| ☐Change in needs | ☐Pressure ulcers |
| ☐Specialist controls | ☐Specialist seating |
| **EXTERNAL PRESCRIPTION:** | [ ]  Please complete the request form at the end of this referral and attach any appropriate risk or clinical assessment |

**Service user details:**

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| --- | --- | --- | --- |
| **User’s first name:** |  | **NHS number:** |  |
| **User’s surname:** |  | **Title:** | Mr | Mrs | Miss | Ms | Dr | Other |
|  |  |  |[ ] [ ] [ ] [ ] [ ]   |
| **Date of birth:** |  | **Ethnic group:** |  |
| **Care needs:** | [ ]  Low | [ ]  Med | [ ]  High | [ ]  Specialist | **Does this person have a religious belief?** |  |
| **Does user have capacity?** | [ ]  If user **does not** have capacity include contact details of who will act in their best interests | **This individual represents a safety concern for lone workers**[ ]  **Yes:**  |
| **Address (including postcode):** |  | **Main contact (if not user):** |  |
| **Telephone number:** |  | **Funding source:** | ☐ Local healthcare funding |
| **Mobile number:** |  |  | ☐ Continuing Healthcare |
| **Email:** |  |  | ☐ Other: |
| **Communication issues:** | [ ]  None | [ ]  Non-verbal | [ ]  Non-communicative | [ ]  Interpreter: |

**Professionals and services involved in user’s care:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service type** | **Service name** | **Main contact** | **Contact details** |
| **Community OT** |  |  |  |
| **Community Physio** |  |  |  |
| **Education/Work** |  |  |  |
| **Learning disability service** |  |  |  |
| **Social care** |  |  |  |
| **Speech & Language** |  |  |  |
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**GP details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Email:** |  |
| **Surgery and address (including postcode):** |  | **Telephone number:** |  |
| **Fax number:** |  |

**Medical details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Height:** |  | **Diagnosis:** |  |
| **Weight:** |  |  |  |
| **Hip width:** |  | See diagram on page 3 for further details |  |  |
| **Seat depth:** |  |  |  |  |
| **Knee to heel length:** |  |  | **Considered to have a terminal illness (ie <6 months)** | ☐ |
| **Able to self-propel?** | [ ]  Yes | **Known to the Specialist Palliative Care Team or has a DS1500 (or equivalent) form:** | ☐ |
|  | [ ]  No |  |  |
| **Walking ability:** | [ ]  Unable to walk | **Considerations for seating provision (for completion by medical professional – if unknown please leave blank):** | **Contractures which would prevent normal sitting** | Hip | Knee | Ankle |
| **Recent history of falls** [ ]  | [ ]  With equipment indoors |  |  | [ ]  | [ ]  | [ ]  |
|  | [ ]  Independent | **Distance:** |  |  | [ ]  Specialist controls | [ ]  PEG  |
| **Sitting balance:** | [ ]  Needs support |  | [ ]  On-chair AAC | [ ]  Ventilated/oxygen |
|  | [ ]  Able to sit unaided |  | **Continence issues** | [ ]  Catheter  |
| **Transfer ability:** | [ ]  Hoist |  | Bladder [ ]  | Bowels [ ]  | [ ]  Suprapubic catheter  |
| **Hoist type:** |  | [ ]  With assistance |  |  |  | [ ]  Pads |
|  |  | [ ]  Independent  |  | Scoliosis | Mild | Mod | Sev |
| **How often will the wheelchair be used?** | [ ]  Daily |  |  | [ ]  | [ ]  | [ ]  |
|  |  |  | Kyphosis | [ ]  | [ ]  | [ ]  |
|  | [ ]  More than once a week |  | Pelvic obliquity | [ ]  | [ ]  | [ ]  |
|  | [ ]  Once a week or less |  | Spasticity | [ ]  | [ ]  | [ ]  |
| **Where will the wheelchair be used most often?** | [ ]  Indoors |  | ↑Tone | [ ]  | [ ]  | [ ]  |
|  | [ ]  Indoors and outdoors |  | ↓Tone | [ ]  | [ ]  | [ ]  |
|  | [ ]  Outdoors |  | ↑Foot deformity | [ ]  | [ ]  | [ ]  |
| **How long will the user be seated in the chair during the day?** | <2hr | 2-4hr | 4-8hr | >8hr | **Current wheelchair (if applicable):** |  |
|  |[ ] [ ] [ ] [ ]   |  |
| **Is it likely that review by Community Occupational Therapy will be required for home adaptations?** | [ ]  Not required/already adapted | **Current cushion / seating system (if applicable):** |  |
|  | [ ]  I have already referred to this service |  |  |
|  | [ ]  I will be referring to this service |  |  |
| **Are there currently potential issues with using a wheelchair in the property?** | [ ]  Steps into property | [ ]  Access to bathroom | [ ]  Carer health issues |
|  | [ ]  Narrow doors | [ ]  No charging location | [ ]  Transfer issues (including carer support with hoisting etc) |
|  | [ ]  Tight turns | [ ]  Lack of storage for equipment |  |
| **Property dimensions:** | **Front door:** |  | **Narrowest internal door:** |  | **Hallway:** |  |

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| **Please provide any additional details about this person or their needs** (Please also include any information relating to any safety concerns for lone workers if this has been raised as an issue)**:** |
|  |

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| **PRESSURE ULCER RISK ASSESSMENT – BRADEN SCALE****Users with existing or previous pressure damage are immediately high risk** |
| **Sensory perception** – *ability to respond meaningfully to pressure related discomfort* | **Mobility** – *ability to change and control body position* | **Moisture** – *degree to which skin is exposed to moisture* |
| 1. Completely Limited |[ ]  1. Completely immobile |[ ]  1. Constantly moist |[ ]
| 2. Very Limited |[ ]  2. Very Limited |[ ]  2. Very moist |[ ]
| 3. Slightly Limited |[ ]  3. Slightly Limited |[ ]  3. Occasionally moist |[ ]
| 4. No impairment |[ ]  4. No limitations |[ ]  4. Rarely moist |[ ]
|  |
| **Activity** – *degree of physical activity* | **Nutrition** – *Usual food intake* | **Friction and Shear** |  |
| 1. Bed bound |[ ]  1. Very poor |[ ]  1. Problem |[ ]
| 2. Chair bound |[ ]  2. Probably inadequate |[ ]  2. Potential problem |[ ]
| 3. Walks Occasionally |[ ]  3. Adequate |[ ]  3. No apparent problem |[ ]
| 4. Walks frequently |[ ]  4. Excellent |[ ]   |  |
| Existing or previous pressure damage: | [ ]  - *High Risk* | Total Score |  |
| Location and grade of previous pressure ulcer(s): | 16+ = Low risk13 – 15 = Medium riskLess than 12 = High risk |[ ]
|  |  |[ ]
|  |  |[ ]

To be used in conjunction with clinical judgement. Please note lower scores indicate a higher risk of pressure ulcer development.

Information on other Risk Factors which would indicate a requirement for pressure management (E.g. sitting posture, transfer technique, etc):

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**Measurement guide:**

|  |  |
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|  | **Hip width:*** The width of the widest part of the hip
* Ensure that the tape measure does not bend when measuring

**Seat depth:*** From the back of the knees to the rear-most part of the bottom

**Calf length:*** From the back of the knee to the floor/under the heel
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**External Prescription**

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| **Manual Wheelchair** WILL BE SUPPLIED WITH STANDARD 2” CUSHION, UNLESS OTHERWISE STATEDPLEASE NOTE A REQUEST CAN ONLY BE MADE IF THE CLIENT MEETS THE ELIGIBILITY CRITERIA  |
| [ ]  **Manual Self Propel*** Suitable for adults up to 21 stone
* Weight of chair 38lbs / 18kg
* Does not have medical contraindications
 |  | [ ]  **Manual Attendant-Propel*** suitable for adults up to 21 stone
* weight of chair 34 lbs / 15kg
 |  |
| **Electric Indoor/Outdoor Power Chair**PLEASE NOTE A REQUEST CAN ONLY BE MADE FOR POWER IF THE CLIENT MEETS THE POWER CHAIR ELIGIBILITY CRITERIA. |
| [ ]  **Electric Indoor Only Chair** | Image result for line art house | [ ]  **Electric Indoor/Outdoor Chair** | Image result for line clipart front gardenImage result for line art house |
| Can the user safely and effectively self-propel a manual wheelchair indoors? | [ ]  Yes | No [ ]  |
| Does the client have any visual impairment that would affect their ability to drive an Electric Wheelchair safely? | [ ]  Yes | No [ ]  |
| Does the client have any cognitive or visuo-spatial issues, or suffer from hearing impairment, epilepsy or other causes of loss of consciousness? | [ ]  Yes | No [ ]  |
| If yes to any questions above please provide details in the below space: |
| **Size required (width x depth):** | [ ]  17x17” (standard) | [ ]  width: x depth:  |
| **Additional equipment required:** | [ ]  Stump board (left) | [ ]  Stump board (right) | [ ]  Oxygen carrier | [ ]  Vent / equipment tray | [ ]  Headrest |
| [ ]  Other: |  |
| **Equipment required for:** | [ ]  Mobility in the home | [ ]  Personal Care | [ ]  Outdoor Leisure  |
| [ ]  Work/Education | [ ]  Day Centre(s) | [ ]  GP/Hospital Appointments |

**By placing this referral I acknowledge that this individual is either unable to, or is unsafe mobilising without a wheelchair, and that a wheelchair would be their primary means of mobility indoors, within their home.**

**Referrer details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Email:** |  |
| **Profession:** |  | **Telephone:** |  |
| **Address (including postcode):** |  | **Accreditation number (where applicable):** |  |
| [ ]  **I would like to be invited to any appointments that are made**  | **Signature:** |  |
| **I have obtained the patient’s consent to refer to AJM:** [ ] **OR – I am acting in their best interests by referring:** [ ]  | **Date form completed:** |  |