**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 F2 Crabtree Manorway North, Belvedere, DA17 6AX  [**EMAIL**](mailto:derbyshire@ajmhealthcare.org)**:**[ajm.bexleywheelchairservice@nhs.net](mailto:ajm.bexleywheelchairservice@nhs.net)  **Tel:** 08081962008 |

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

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| --- | --- | --- | --- | --- | --- | --- |
| **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:**

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| --- | --- | --- | --- | --- | --- |
| **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:**

|  |  |  |  |
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| **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:**

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

**Medical details:**

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| **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 risk  13 – 15 = Medium risk  Less than 12 = High risk |  |
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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 |

**External Prescription**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Manual Wheelchair** WILL BE SUPPLIED WITH STANDARD 2” CUSHION, UNLESS OTHERWISE STATED  PLEASE 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](http://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&ved=2ahUKEwiRqenjit_iAhVQA2MBHR_6DxcQjRx6BAgBEAU&url=http%3A%2F%2Fclipart-library.com%2Fhouse-line-cliparts.html&psig=AOvVaw360Q7k5h4NZqCTSZTFaqjW&ust=1560261923641006) | | | | **Electric Indoor/Outdoor Chair** | | | | | [Image result for line clipart front garden](https://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&ved=2ahUKEwiGtqHbi9_iAhU6BGMBHamRDqcQjRx6BAgBEAU&url=https%3A%2F%2Ficonscout.com%2Ficon%2Ffront-yard-garage-garden-tree-car-parking&psig=AOvVaw2ee0eSL78rrYDyUmuRqMB8&ust=1560262172517342)[Image result for line art house](http://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&ved=2ahUKEwiRqenjit_iAhVQA2MBHR_6DxcQjRx6BAgBEAU&url=http%3A%2F%2Fclipart-library.com%2Fhouse-line-cliparts.html&psig=AOvVaw360Q7k5h4NZqCTSZTFaqjW&ust=1560261923641006) |
| 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:**

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| **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:** |  |