North Yorkshire and York Wheelchair Service
Wheelchair & Specialist Buggy Referral Form

Referrals will be accepted from any healthcare professional. Re-referrals can also be made using this form.
Please complete all sections fully. Incomplete forms will be returned to the referrer.
We do not provide wheelchairs to ANY care homes for portering purposes; this is the responsibility of the care home.
Wheelchairs for short term use are not provided by the wheelchair service.

Client's Personal Details

Title Please select Gender Male Female

Surname

Forename(s) Date of Birth

Preferred Name NHS Number

Home Address Delivery Address

Post Code Post Code

Tel No. Contact

Mobile No. Tel No.

Email Address

Main Language Will an interpreter be required? Yes No

Preferred method of communication: Phone Email

Ethnic Origin Religion

Disability

Relevant Medical Details

Critical Case (e.g. terminal illness) Yes No Reason

Essential for hospital discharge? Yes No Date

Is this person already in possession of an NHS wheelchair? Yes No

Will the patient require ambulance transport? Yes No If yes, will a stretcher be required? Yes No

Details of GP

Name Address

Tel No.

GP Practice Code Post Code

Details of Prescriber (if different to GP)

Name Address

Tel No.

Profession Post Code

Would you like to be present at the assessment? Yes No

Signature (if filled in by hand

Date

Main reason for referral

Assessment Details: Wheelchair

What is the person's walking ability within the home? Please select

What is the person's transfer method? Please select

How often will the wheelchair be used? Please select

Is the person required to sit in their wheelchair when travelling in a vehicle? Yes No

Is this wheelchair required for Indoor Outdoor Both

Assessment Details: Cushion

Is standard foam cushion adequate? Yes No If yes: Select height

Will the patient be using the wheelchair for more than 4 hours at a time? Yes No

Suggested cushion?

What is the maximum duration the person will sit in the wheelchair in one session? Select duration

Can the person maintain sitting balance in the wheelchair? Yes No

Person's tissue status:

Previous pressure ulcer(s): Yes No

Site Category

Present pressure ulcer(s): Yes No

Site Category

Continence status: Please select

Who will maintain and monitor cushion?

Waterlow score

Type of wheelchair required

Person has limited walking ability, likely to be in excess of six months or is terminally ill.

Self Propelling Please select

Attendant wheelchair Please select

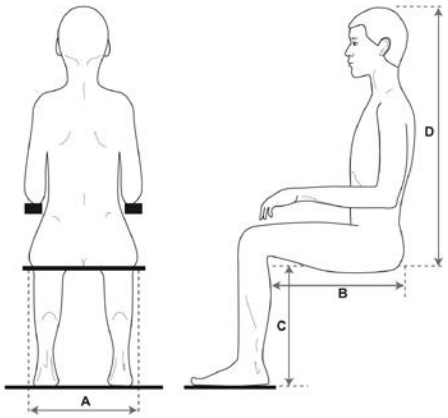
Powered Wheelchair Please select

Buggy Comments:

Measurements

Height Weight

A = Hip width	● cms	● ins
B = Back of buttocks to back of knee	● cms	● ins
C = Back of knee to sole of foot	● cms	● ins
D = Seat to top of head	● cms	● ins



Further assessment by Wheelchair Service Team

Is further assessment required by York Wheelchair Service? Yes No

Interested in PWB? Yes No

Preferred service location: York Harrogate Scarborough Northallerton

Powered wheelchairs only

For powered wheelchairs the medical questionnaire below must be completed.

Please note that we do not provide scooters, powered chairs for outdoor use only nor attendant operated powered wheelchairs.

Medical questionnaire section

Please complete the request for medical information, which is needed before an assessment can be arranged for a powered wheelchair for your patient. Please tick the selected answer.

1. Mobility: In your opinion, is this person unable to walk or self propel a manual wheelchair, or are they medically at risk to do so? ☐ Yes ☐ No

Comments:?

2. Is this patient affected by the following?:

A. Epilepsy/blackouts ☐ Yes ☐ No Has the patient had a seizure in the past year? ☐ Yes ☐ No

B. Any medication or their side effects: ☐ Yes ☐ No

Comments:?

C. Visual impairments ☐ Yes ☐ No

Please give details:

D. Mental health problems (relevant to safe wheelchair use) ☐ Yes ☐ No

Comments:?

E. Challenging behaviour may affect safe use of a powered wheelchair ☐ Yes ☐ No

Comments:?

F. Perceptual deficits e.g. neglect ☐ Yes ☐ No

G. Any other conditions that may affect safe use of a powered chair?

Comments:?

3. In my opinion, this individual is medically fit to control an EPIC (Electrically Powered Indoor wheelchair) ☐ Yes ☐ No

Signature (if completed by hand)

Print Name Date

York Wheelchair Centre, NRS Healthcare, Unit 13, Stirling Park, Bleriot Way, Clifton Moor, York, YO30 4WU
01904 654052
Email: **nrs.northyorkswheelchairs@nhs.net**