**THERAPY SERVICES – Self Referral to Wheelchair Services**

**Please complete all sections and send via email to: Wheelchair.SelfReferrals@bthft.nhs.uk**

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| **Patients must meet ALL of the following criteria to be assessed for an NHS wheelchair (TICK ALL)**  £ Registered with a GP in the Bradford  £ Lawfully entitled to reside in the UK and to receive NHS treatment for use in their own home  £ Has an identified long term medical condition including palliative care needs requiring a wheelchair  £ Has a long term\* mobility problem and is classified as unable to, or virtually unable to walk indoors  \*Long term is more than 6 months  Wheelchair services **DO NOT PROVIDE**   |  |  | | --- | --- | | * Wheelchairs for short term use * Adult wheelchairs for occasional outdoor use only * Wheelchairs in the place of a suitable static seat | * Powered outdoor only wheelchairs * Mobility scooters * Wheelchairs for shared use | | | | | |
| **PATIENT DETAILS REFERRAL DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| Title Mr / Mrs / Miss / Dr / Other  Name:  Date of Birth: | | | | |
| Address  Postcode  Is the property adapted for wheelchair use:  Yes £ No £ | | | Telephone Numbers  Day Number :  Evening Number:  Mobile Number: | |
| Carer’s/Next of kin name and telephone number: | | | Do we have consent to contact your GP  Yes £ No £ | |
| GP’s Name and Address | | | | |
| Tel No: | | | | |
| Ethnicity:    Language (If not English): Interpreter required: £ Yes £ No | | | | |
| **DIAGNOSIS AND CURRENT PHYSICAL DISABILITIES IN RELATION TO INABILITY TO WALK – PLEASE INCLUDE MEDICATIONS** | | | | |
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| **WHAT IS CURRENTLY BEING USED** | | | | |
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| **CURRENT CLIENT MOBILITY** | | | | |
| £ Unable to walk £ Limited indoors can walk with aid £ Limited Outdoors  Can the you transfer independently?£Yes £ No If No please specify: | | | | |
| **CLIENT MEASUREMENTS** | | | | |
| Client height (m) |  | Client weight (kg) | |  |
| **PLEASE TELL US WHY YOU ARE WANTING A WHEELCHAIR ASSESSMENT** | | | | |
| **Please tell us the type of assessment you want us to do**  Manual Transit (for someone else to push) £  Manual Self Propelling (for you to use the wheels) £ Please confirm can self propel, no heart or breathing conditions  Postural Assessment (are you leaning, unable to sit on own) £ Please provide some details  Indoor Powered £ No outside steps or access issues, room for the chair – Home assessment will be completed  Indoor/Outdoor Powered £ No epilepsy or seizures, good visual acuity no eyesight issues or reasons why a powered chair would not be safe. Home assessment will be completed.  **Please tell us about any hearing, eyesight or communication impairments**      **What are your expected goals (tick as many as applicable)**  £ Increase mobility in the home £ Increase mobility outdoors £ Reduce risk of falls £ Improving functional ability £ Maintain or increase independence £ Pressure relief | | | | |
| **How often do you expect to use the Wheelchair?**  £ Occasionally £ Daily £ Weekly  **For how long?**  £ Short periods £ 2-3 hours £ All day without relief  **What will the main use of the Wheelchair be?**  £ Moving around the house £ Social Outings £ Shopping £ Day/Training Centre  £ School/College/Work £ Nursing Home £ Residential Home £ In the garden | | | | |
| Does you already have a wheelchair? £ Yes £ No | | | | |
| Would you like information regarding personal wheelchair budgets where you can put a financial contribution to the wheelchair for additional upgrades/colours/accessories: £ Yes £ No | | | | |