**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 monthsWheelchair services **DO NOT PROVIDE**

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| * 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
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| **PATIENT DETAILS REFERRAL DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Title Mr / Mrs / Miss / Dr / OtherName: Date of Birth:  |
| Address PostcodeIs 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 GPYes £ 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 OutdoorsCan 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 completedIndoor/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 |