

# Wheelchair & Specialist Buggy Referral Form

This form should be completed by the patient's Healthcare Professional for wheelchairs or buggy requests.

For re-referrals please contact the wheelchair service by phone or email.

Please complete all sections fully. Incomplete forms will be returned to the referrer.

## Client's Personal Details

Title	Gender	Male	Female
Surname	Date of Birth		
Forename(s)	NHS Number		
Preferred Name	Delivery Address		
Home Address			
	Postcode		
Postcode	Contact		
Tel No.	Tel No.		
Mobile No.	Main Language		
Email Address	Will an interpreter be required?	Yes	No
Preferred method of communication: Phone	Email		
Ethnic Origin	Religion		
Disability			
Relevant Medical Details			
Critical Case (eg. terminal illness)	Yes	No	Reason
Essential for hospital discharge?	Yes	No	Date
Is this person already in possession of an NHS wheelchair?	Yes	No	

## Details of GP

Name	Address
Tel No.	
GP Practice Code	Postcode

## Details of Prescriber (if different to GP)

Print Name	Address
Tel No.	
Profession	Postcode
Would you like to be present at the assessment?	Yes No
Signature (if filled in by hand)	Date



## 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

**Please return to: ERY and Hull Wheelchair Services, 11 Reed Street, Hull, HU2 8JJ.**

**Email: [hull.wheelchairservice@nhs.net](mailto:hull.wheelchairservice@nhs.net)**