

# ERY and Hull Wheelchair Service - GP Referral form

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

**Please note this form must not be completed by the client**

We do not provide wheelchairs to ANY care homes for portering purposes; this is the responsibility of the care home.

## Details of GP\*

Name	Print Name
Address	Date
	GP Practice Code
Postcode	
Tel No.	

## Client's Personal Details

Title	Gender	Male	Female
Surname	Forename(s)		
Date of Birth	NHS Number		
Home Address	Tel No.		
	Mobile No.		
Postcode			
Is this a looked after child?	Yes	No	
Preferred method of communication: Phone		Email	
Main Language			
Ethnic Origin	Religion		
Disability			
Relevant Medical Details			

Critical Case (eg. terminal illness)      Yes      No

Hip Width (please measure in a straight line across the pelvis)

Weight      Height

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

Is the individual registered as a Veteran with your GP Practice?      Yes      No

## Postural Needs

Has this person any postural needs we need to be aware of?      Yes      No

If yes, please specify:

\*Essential information

## Requirements

How often will the wheelchair be used?

### Type required:

- Non-powered self propelled chair
- Non-powered attendant pushed chair
- Powered wheelchair

Is this wheelchair required for    Indoor    Outdoor    Both

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

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

### Accessories

Any accessories required? (please list)

### Cushion

Is standard foam cushion adequate?      Yes      No

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

Does this person have any pressure ulcers at present?      Yes      No

If yes, please state site and category of ulcer:

Waterlow score

Continence Status

Additional Information

GP Signature (if completed by hand)

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

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

**If a powered wheelchair is requested please fill in the section on the following page as we require additional information to ensure the safety of both patient and other pedestrians when the powered wheelchair is in use.**

## Powered Wheelchairs Only; please complete this section

### Medical Questionnaire Section

This is needed before a driving 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:?

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**3. In my opinion, this individual is medically fit to control a powered wheelchair**    Yes    No

**GP Signature** (if completed by hand)

Print Name

Date

**Any amendments MUST be signed and dated by the GP**

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

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