NHS
Humber and North Yorkshire
Integrated Care Board (ICB)

Service provided by AJM HealthCare

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Hull and East Riding of Yorkshire Wheelchair Service Referral Form

This form is to be completed by a registered health or social care professional. Please ensure you have read our eligibility criteria, which can be found on our website: https://hullandeastriding.wheelchair.services

Please complete the form in full. Mandatory fields are marked in red. Incomplete forms may be returned to you and may cause delays. This form is designed for completion on-screen. We recommend using Adobe Acrobat software.

For assistance with this form, please call the wheelchair service on 0808 175 3969. When complete, please return your referral form using a secure email service to ajm.ery-hullwheelchairservice@nhs.net.

01. Prioritisation Information

Is the service user receiving palliative care?	☐ Yes ☐ No	Discharge date:	
Are there current grade 3/4 pressure injuries?	☐ Yes ☐ No	Discharging from hospital/ward:	
Is this referral required for hospital discharge?	☐ Yes ☐ No	Discharging to:	

02. Service User Details

Title:		Does the service user have capacity?	☐ Yes ☐ No
Forename(s):		If no, who will act in their best interests?	
Surname:		Relationship:	
Telephone/mobile:		Telephone/mobile:	
Email:		Email:	
Address, including postcode:		Address, including postcode: Copy from left	
Are there any risks to staff visiting the address?	☐ Yes ☐ No	Is this person a "Looked After Child"?	☐ Yes ☐ No
If yes, details:		If yes, details/funding:	
Date of birth:		Is this person CHC or CC funded?	☐ Yes ☐ No
NHS Number:		If yes, details/funding:	
Any religion/belief:		Is this person a prisoner?	☐ Yes ☐ No
Ethnicity:		If yes, details/funding:	
Communication needs:			

03. GP Details

GP Name:		Address, including postcode:	
Telephone:			
Email:			

04. Reason for Referral

☐ **Option 1.** Please assess this person.

They require:

☐ **Option 2.** This person is an existing wheelchair service user. Please review their existing provision.

The main reason for review is:

☐ **Option 3.** Please assess this person for a powered wheelchair. I confirm I have read the eligibility criteria for powered wheelchair provision.

They require:

Can they safely and effectively self-propel a manual wheelchair indoors? ☐ Yes ☐ No

Do they have any visual impairments which would affect their ability to safely drive a powered wheelchair? ☐ Yes ☐ No

Do they have any cognitive or visuo-spatial issues, or suffer from hearing impairment, epilepsy or any other conditions which can cause loss of consciousness? ☐ Yes ☐ No

If you have answered yes to any of these questions, please provide details in the space below.

☐ **Option 4.** I am a Wheelchair Approved Prescribed (WAP) or an Advanced Wheelchair Approved Prescriber (AWAP) and I will complete the Prescription Request section at the end of this form.

Please provide any further details about your reason for referring this person here:

05. Existing Care Arrangements

Formal carers

Service name:

Frequency of care:

Contact details:

Contact name:

Informal carers

Name/details:

Frequency of care:

Contact details:

Contact name:

Occupational Therapy

Service name:

Contact details:

Contact name:

Social care

Service name:

Contact details:

Contact name:

Physiotherapy

Service name:

Contact details:

Contact name:

Speech and Language Therapy

Service name:

Contact details:

Contact name:

Education/Work

Service name:

Contact details:

Contact name:

Any other relevant organisation

Service name:

Contact details:

Contact name:

06. Medical Details

Height: cm

Weight: kg

Diagnosis / medical condition / reason for referral:

Can the person self-propel? Yes No

Is there a recent history of falls? Yes No

Is this person considered to have a terminal illness (i.e. <6 months)? Yes No

Are they known to a palliative care team or do they have a DS1500 (or equivalent) form? Yes No

What is their mobility status?

How long are they able to maintain a sitting balance unaided?

How often will the wheelchair be used?

How long will they be seated in the chair each day?

Where will the wheelchair be used most often?

How do they transfer / what is their transfer ability?

What wheelchair do they currently use, if any?

What cushion/seating system do they currently use, if any?

Hip width: cm

- The width of the widest part of the hip
- Ensure that the tape measure does not bend when measuring

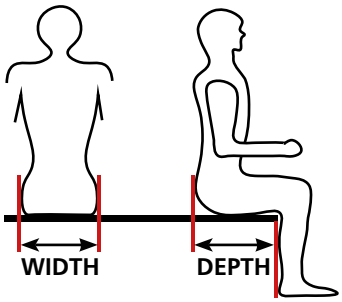
Seat depth: cm

- From the back of the knees to the rear-most part of the bottom

Knee to heel length: cm

- From the back of the knee to the floor, under the heel

Measurement Guide



Are there any considerations for seating provision? For completion by medical professionals. Please leave blank if unknown.

- Specialist controls may be required
- Use of PEG feeding tube
- Augmentative/Alternative Communication (AAC) needs
- Use of ventilator or oxygen
- Continence issues with bladder
- Continence issues with bowels
- Use of a catheter
- Use of a suprapubic catheter
- Use of incontinence products, e.g. absorbent pads

Contractures preventing normal sitting	Hip	Knee	Ankle
Scoliosis	Mild	Moderate	Severe
Kyphosis	Mild	Moderate	Severe
Pelvic obliquity	Mild	Moderate	Severe
Spasticity	Mild	Moderate	Severe
Increased tone	Mild	Moderate	Severe
Decreased tone	Mild	Moderate	Severe
Increased foot deformity	Mild	Moderate	Severe

Please provide any additional details about the person or their needs. If none, please state "n/a".

07. Home Environment

Are there currently any potential issues with using a wheelchair in the home environment? If yes, please select the options that apply below. ☐ Yes ☐ No

☐ Steps into property	☐ Bathroom access	Front door width:		cm
☐ Narrow doorways	☐ Lack of storage space	Narrowest door width:		cm
☐ Tight turns	☐ No charging location	Hallway width/turns:		cm
☐ Multiple floors, no lift	☐ Multiple floors, with lift			

Is it likely that home adaptations will be required?

08. Pressure Ulcer Risk Assessment

Location and grade of previous pressure ulcers:

Are there risk factors which would indicate a requirement for pressure management, e.g. sitting posture, transfer technique, duration of sitting, etc.? If no, state "n/a".

Assessment Option 1 - Braden Scale for Predicting Pressure Sore Risk

Users with existing or previous pressure damage are immediately high risk. To be used in conjunction with clinical judgement. Select the appropriate option from each dropdown and then add the scores. Lower scores indicate a higher risk.

Sensory perception - ability to respond meaningfully to pressure related discomfort:

Mobility - ability to change and control body position:

Moisture - degree to which skin is exposed to moisture:

Activity - degree of physical activity:

Nutrition - usual food intake:

Friction and shear:

Total score:

Assessment Option 2 - Waterlow Pressure Sore Risk Assessment Tool

Select the appropriate option from the tickboxes and then add the scores. More than one score/category can be used.

Build/weight for height

☐ Average BMI 20–24.9	0
☐ Above Average BMI 25–29.9	1
☐ Obese BMI > 30	2
☐ Below Average BMI < 30	3

Skin type visual risk areas

☐ Healthy	0
☐ Tissue Paper	1
☐ Dry	1
☐ Oedematous	1
☐ Clammy, pyrexia	1
☐ Discoloured, grade 1	2
☐ Broken spots, grade 2–4	3

Sex and Age

☐ Male	1
☐ Female	2
☐ 14–49	1
☐ 50–64	2
☐ 65–74	3
☐ 75–80	4
☐ 81+	5

Malnutrition Screening Tool (MST)

A. Has the patient lost weight recently?
If yes, complete B below.
If no, complete C below.
If unsure, go to C and add 2.

C. Is the user eating poorly or lacking appetite?

☐ No	0
☐ Yes	1

B. Weight Loss Score

☐ 0.5–5 KG	1
☐ 5–10 KG	2
☐ 10–15 KG	3
☐ > 15 KG	4
☐ Unsure	2

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Mobility

☐ Fully	0
☐ Restless/fidgety	1
☐ Apathetic	2
☐ Restricted	3
☐ Bedbound, e.g. traction	4
☐ Chairbound, e.g. wheelchair	5

Continence

☐ Complete or catheterised	0
☐ Urinary incontinence	1
☐ Faecal incontinence	2
☐ Urinary and faecal incontinence	3

Special Risks

Tissue Malnutrition

☐ Terminal cachexia	0
☐ Multiple organ failure	1
☐ Single organ failure	2
☐ Peripheral vascular disease	3
☐ Anaemia (Hb < 8)	4
☐ Smoking	5

Neurological Deficit

☐ Diabetes, MS, CVA	4–6
☐ Motor / sensory	4–6
☐ Paraplegia (max of 6)	4–6

Major Surgery or Trauma

☐ On table >2 hrs*	5
☐ On table >6 hrs*	8
☐ Orthopaedic / spinal	5

Medication - cytotoxics, long term or high dose steroids, anti-inflammatories ☐ 0–4

Total Score:

Score Key:
10+ = at risk
15+ = high risk
20+ = very high risk

* Scores can be discounted after 48 hours provided the patient is recovering normally. Reproduced from www.judy-waterlow.co.uk

09. Referrer Details

Name:

Email:

Profession / role:

Telephone:

Address:

Accreditation number:

I have obtained this person's consent for this referral:

OR I am acting in this person's best interests by referring:

Signature:
If completing on-screen, please write your name in this box and send from your personal email.

I would like to be invited to any appointments made:

Date:

10. Approved Prescriber Prescription Request

This section should only be completed by those who have attended the Wheelchair Approved Prescriber (WAP) or Advanced Wheelchair Approved Prescriber (AWAP) training provided by the wheelchair service. All other referrers should leave this section blank. If you are interested in becoming a WAP/AWAP, please contact us as above.

WAP/AWAP Number:

I confirm this request meets the service eligibility criteria:

I confirm I have informed this person about their legal right to a Personal Wheelchair Budget:

This person has requested a PWB assessment:

Please select the type of wheelchair required:

Option 1. Please provide a manual self-propel wheelchair.
- Suitable for adults up to 133kg (21 stones) in weight
- The wheelchair will weigh approximately 18 kilograms (38 pounds), excluding any accessories chosen
- The user should not have any medical contraindications

Option 2. Please provide a manual attendant propel wheelchair.
- Suitable for adults up to 133kg (21 stones) in weight
- The wheelchair will weigh approximately 15 kilograms (34 pounds), excluding any accessories chosen

Option 3. Please provide a tilt-in-space wheelchair.
This option is only available for Advanced Wheelchair Approved Prescribers (AWAP)

Please select the dimensions and any additional accessories required below. Wheelchairs are provided with a 2" cushion as standard. If you select a specialist cushion, please ensure you have completed the Pressure Ulcer Risk Assessment section above.

Size required:

Specialist cushion:

Elevating leg rest (left): Yes No

Stump board (left): Yes No

Elevating leg rest (right): Yes No

Stump board (right): Yes No

Oxygen carrier: Yes No

Anti-tipper (left and right) Yes No

Vent / equipment tray: Yes No

Headrest: Yes No

Other equipment:

Please state why the equipment is required, ticking all that apply:

- Hospital discharge short term loan
- Attending GP/hospital appointments
- Personal care
- Mobility in the home
- Work or education
- Outdoor leisure
- Attending day centre(s)
- Other:

Thank you for completing the referral form. If you would like to provide feedback on this form, or any other aspect of the wheelchair service, please email ajm.ery-hullwheelchairservices@nhs.net. Your feedback is important to us.