Bridgewater Community Healthcare NHS
NHS Trust

Date Rec	
Clinic Appt	

Wheelchair Service
Referral Form for Wheelchair & Accessories

***Please complete in* PRINT including all information -INCOMPLETE forms will be returned for Completion**

NHS No:	D.O.B

Male ☐ Female ☐ Would Prefer not to say ☐ Ethnicity:	Name: Address:

Are you currently or have you ever been a member of the armed services community?
Yes ☐ No ☐
If yes, please give details

Receipt of continuing care? Yes ☐ No ☐ Receipt of war pension? Yes ☐ No ☐

Post code: Email Address:	Telephone Number:
Next of Kin/ Main Carer	Telephone Number:

If carer wishes to be informed of an appointment please give address and telephone number for contact

General Practitioner	Telephone Number:
Address	

Attending School /Day Centre /Rehab /In-patient:	
Therapist Name:	Telephone Number:
Base:	

Primary Diagnosis/Medical History:

Is client medically fit to self-propel a wheelchair? Yes ☐ No ☐ Is client on oxygen? Yes ☐ No ☐
Is the client able to use their upper limbs in order to self-propel a wheelchair? Yes ☐ No ☐
Does the client have any visual difficulties? Yes ☐ No ☐
If so - please give details

Height:	Weight:

Please tick the box that best describes patients current level of mobility:
☐ Walks independently from room to room indoors at home
☐ Walks with the use of a mobility aid from room to room indoors at home
☐ Can take a few steps with assistance from room to room indoors at home
☐ Chair bound (ie: cannot stand alone or weight bear and has no mobility whatsoever indoors)
☐Other……..

Transfer Method: (please tick) Independent □	Assisted 1 □ 2 □	Hoisted □

Does the patient already have a wheelchair? Yes □ No □

Type of wheelchair/s: _____

WLO NO: _____ Type of cushion: _____

Is patient currently an In-patient? Yes □ No □ Please give details of Hospital/Ward below:

Discharge date: / / (*if date unknown please contact wheelchair service to advise of discharge plans ASAP*)

Reason for Referral: (*please tick AND provide further information below*)

Wheelchair Voucher Scheme □
Manual Attendant Pushed Wheelchair □
Manual self-propelling Wheelchair □
Postural Support □
Electronic Indoor powered Wheelchair (EPIC) □
Electric indoor/outdoor Powered Wheelchair (EPIOC) □
Childs Provision □

Potential Health & Safety risks MUST be identified

Please give name & any contact details of any other service involved. i.e. Physio

How will the client travel to the wheelchair service for assessment?

Are there any issues with the client's carer that need to be considered?

Is the client working? Yes □ No □
If so – what is their occupation?

Will an interpreter be need for assessment? Yes □ No □
If so what language is spoken by the client?

Name: _____ Designation: _____
(Referring Health Professional)

Base: _____ Contact Tel: _____

Has the client given consent to referral? Yes □ No □

Signature: _____ Date: _____/_____/_____

Please send completed Referral Form to:

Bridgewater Community Healthcare NHS Trust
Halton & St Helens Wheelchair Service, ILC, Collier Street, Runcorn WA7 1HB
Tel: 01928 582939 Email: bchft.haltonwheelchairservice@nhs.net

* Please note - any incomplete referrals will be returned *

For Office Use Only:

May 2013. Updated August 2018