Blatchford

Derbyshire HCPC Wheelchair & Specialist Buggy Referral Form

Please ensure that all sections are completed in full. Failure to do this may result in unnecessary delays.
The patient must have a permanent physical impairment or medical condition that affects their ability to walk and will need a wheelchair for more than 6 months.

Important Recommendations

- Do not complete from an internet browser due to incompatibilities, (right click and save file to secure location).
- Use the latest Adobe Acrobat DC Reader.
- Use the submit button at the bottom of this form to send the data to the service.
- Dates must be keyed in full DD/MM/YYYY format.
- Signature is not mandatory at this stage but may be required in the future, register for a Digital Signature.
- This form should be completed by the Service User's Healthcare Professional for wheelchairs or buggy requests.
- Enquiries to cabsl.derbyshirewheelchairservice@nhs.net

PATIENT INFORMATION ***ESSENTIAL INFORMATION***								**GP DETAILS**							
NHS No *								GP Name*							
Title *								GP Code							
First Name *								GP Address*							
Surname *								GP Phone No.							
Address *															
Town															
County															
Postcode *															
Date of Birth *								Email							
Phone No. *								Mobile No.							
Preferred method of communication				Phone	◯			Text	◯			Email	◯		
Gender *	Male	◯	Female	◯	Other	◯		Prefer to be described as							
Ethnicity *								Main Language*							
Religion								Interpreter Required*			Yes	◯	No	◯	

DELIVERY ADDRESS (if different from above)	
Name of contact person	
Address	
Town	
County	
Postcode	
Contact details	

Blatchford

MEDICAL DETAILS					
Disability / condition*					
Relevant Medical History and current issues relevant to mobility *					
Critical case (e.g. end of life care)	Yes	◯	No	◯	
Essential for hospital discharge	Yes	◯	No	◯	
Estimated discharge date					
Discharge destination	Home	◯	Care facility	◯	
	Rehab setting	◯	Other	◯	

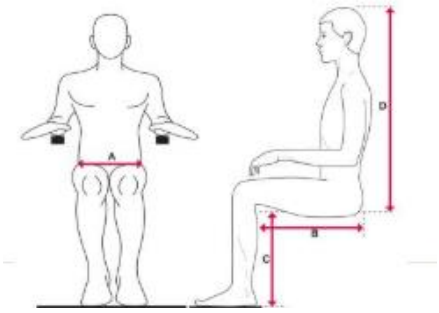
ASSESSMENT DETAILS WHEELCHAIR					
MOBILITY what is the patient's walking ability within the home *					
Walking independently	◯	Walking with equipment e.g. frame	◯	Requires carer assistance	◯
Immobile	◯	Other	◯		
Please specify					
TRANSFERS how does the patient transfer*					
Independent	◯	Standing with assistance	◯	Sliding	◯
With equipment	◯	Hoisted	◯	Other	◯
Please specify					
USAGE How often will the wheelchair be used *					
Occasional use	◯	1 – 2 times a week	◯		
3 times a week or more	◯	Daily	◯		
Other	◯	Please state			

Where will the wheelchair be used *	Indoors	◯	Outdoors	◯	Indoors & outdoors ◯
Does the patient already have an NHS wheelchair *	Yes	◯	No	◯	Unsure ◯
What type of wheelchair do you require*	Transit	◯	Self-Propel	◯	
	Buggy	◯	Powered Wheelchair	◯	

Blatchford

MEASUREMENTS						
Height*	Feet		Inches		Metres	
Weight*	Stone		Lbs		Kilos	

In sitting upright	Inches	Cm
a) Hip width	_____	_____
b) Back of buttocks to back of knee	_____	_____
c) Back of knee to sole of foot	_____	_____
d) Seat to top of head	_____	_____



POSTURE				
Can the person maintain sitting balance in a wheelchair*	Yes	◯	No	◯
Any postural concerns to be aware of *	Yes	◯	No	◯

ASSESSMENT DETAILS CUSHION				
Is a standard foam cushion adequate *	Yes	◯	No	◯
How long on average will the person be sitting in the wheelchair *	1 hour	◯	2 hours	◯
	3 hours	◯	4 hours +	◯
Suggested Cushion				

TISSUE VIABILITY				
Pressure ulcers*	Yes	◯	No	◯
Pressure ulcer location		Pressure ulcer category		
Pressure ulcer detail		Waterlow score		
Continence Status*	Continent	◯	Occasionally incontinent	◯
	Incontinent	◯	Catheterised	◯

PERSONAL WHEELCHAIR BUDGET (PWB)				
Is the patient interested in the Personal Wheelchair Budget (PWB) *	Yes	◯	No	◯
Would like more information	Yes	◯	No	◯
Are there any known problems with the environment that will affect the suitability of the wheelchair	Yes	◯	No	◯
Comments about environment				
Further assessment required by the wheelchair team	Yes	◯	No	◯
Additional accessories required. Please provide clinical reasoning				

Any additional information you would like us to know	

DETAILS OF PRESCRIBER*	
Name	
Profession	
Address	
Telephone number	
Email address	

Would you like to be present at assessment	Yes	◯	No	◯

Privacy and Data Storage Consent

The information you provide in this form is used solely for processing your enquiry and will not be used for any other purpose. Blatchford do not store any backups of the information provided and any information you submit is sent directly to the NHS. For more information, please see our Privacy Policy.

GDPR Consent *

☐ I acknowledge that any personal data submitted by me will be processed in accordance with Blatchford's Privacy Policy

Submit Reset

Following submission of your referral you will receive an email acknowledgement.
If you do not receive confirmation OR if you are unable to SUBMIT this referral, please save the referral as a pdf and attach and send to cabsl.derbyshirewheelchairservice@nhs.net