**North East London Wheelchair Service**

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

**Mobility | Posture | Independence**



**GP Referral Form**

***Please ensure all fields are completed. Referrals received with insufficient information will be returned and may lead to a delay in the referral being processed***

*This form can be completed on paper or electronically, (check boxes can be double-clicked with the mouse ). Do not change the format or structure of this form, corrupted forms will be rejected. Instructions how to send this form are at the end of the document.*

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| --- | --- |
| **Personal Details:** | |
| Title: Mr / Mrs / Ms / Miss / Mstr / Other | Gender: |
| Surname: | First Name: |
| Date of Birth: | NHS No: |
| Home Address: | |
|  | Post Code: |
| Home telephone: | Mobile: |
| Preferred method of contact: | Email Address: |

|  |  |  |
| --- | --- | --- |
| GP Name: | Practice: | |
| Address: | | |
| Post Code: | Telephone No: | |
| Is the Service User under Continuing Healthcare? | Yes | No |
| Additional Information relating to Continuing Healthcare? | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Next of Kin: | | | Nominated Contact Person: | | | |
| Relationship: | | | Relationship: | | | |
| Telephone no: | | | Telephone no: | | | |
| **Power of Attorney:** | | | | | | |
| N/A | EPA | LPA (Finance/ Property) | | | LPA (Health/Welfare) | |
| Details: | | | | | | |
| **Children’s Referral Only:** | | | | | | |
| Primary Carer: | | | | | | |
| Person with Parental Responsibility: | | | | | | |
| Is this child subject to safeguarding plan? | | | | Yes | | No |

|  |  |  |
| --- | --- | --- |
| Does the patient speak English? | Yes | No |
| Does the patient need a qualified interpreter? | Yes | No |
| If yes, please indicate which language: | | |
| What is their preferred language? | | |

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| Medical Conditions / diagnosis (including mental health): | |
| Medication: | |
| Height (estimate) | Weight (estimate) |
| Reason for referral / re-referral: | |

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| --- | --- | --- |
| Is the person is medically unfit to travel? | Yes | No |
| If yes, explain why: | | |
| Is the person dependent on use of supplementary oxygen? | Yes | No |

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| --- | --- |
| **Referrer details** | |
| The service user is aware this referral is being made | |
| I have completed this referral form truthfully and accurately | |
| If possible, I would like to be invited to the wheelchair and seating assessment | |
| Signed: (*not required for electronic submission by GP*)  Date: | |
| Name: | Relationship: |
|  | |
| Address | Post Code: |
| Phone | Fax: |
| Email: | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Wheelchair Requirement** | | | | | | | |
| **Does the person have a wheelchair?** | | | | Yes | | | No |
| If yes, who supplied it? | | | | | | | |
| **What type of wheelchair would they like to be assessed for?** | | | | | | | |
|  | Self-propel (push by yourself) | | | | | | |
|  | Attendant propelled (pushed by someone else) Please state by whom: | | | | | | |
|  | Buggy (for children aged 30 months – 5 years) | | | | | | |
|  | Power wheelchair (powered wheelchairs are not provided for outdoor use only) | | | | | | |
| **Where will the wheelchair be used?** | | | | Indoors | | Outdoors | |
| *(tick as many that apply)* | | | | | | | |
| **How often will the wheelchair be used?** | | | | | | | |
| 1 day a week or less | | Regularly throughout the week | | | | | Daily |
| **Will the wheelchair be required for:** | | | Less than 6 months | | More than 6 months | | |

**Please note:**

1. This form is for completion by GPs wishing to refer to the Wheelchair Service
2. Date of referral received (for wait listing purposes) will only be sent when all essential information has been received
3. Equipment will only be provided for individuals who meet the eligibility criteria for provision
4. Referrals are waitlisted in accordance with the category of equipment required
5. It’s the responsibility of every user who sends a fax to ensure they are sending it to the correct number and we advise that you contact the service to ensure receipt of the referral. The service will not accept any liability if we have not received the referral.

**If you have any queries completing this form please call 0808 169 1040**

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| **Please return this form to:**  **AJM Healthcare**  **Unit B1, Thames View Business Centre**  **Fairview Industrial Park, Barlow Way,**  **Rainham, Essex, RM13 8BT**  **Fax: 0808 133 0184**  **Email:** [**northeastlondon@ajmhealthcare.org**](mailto:northeastlondon@ajmhealthcare.org) |