Peninsula Community Health

PCH Wheelchair Service (PWS) Referral Form

Wheelchair request for those who have permanently limited walking ability.

Date & Time Received:		**By:**		**Ref Type:**	**NEW**		**RE-REFERRAL**	

Title:		NHS No:			
Surname:		Gender:		DoB:	
First Name:		Weight (kg):		Height (m):	

Ethnicity:		Interpreter required:	Y		N		First Language:	

Home Address:		Delivery Address:	
Postcode:		Postcode:	

Tel No:		Mobile:		Email:	
GP Name:		GP Address:		GP Tel No:	

GP Code:	

Others Associated With Client: Next of kin/Carer/Other associated contact:	

Address:			
Tel No:		Email:	

Details of referring Person:			
Name:		Role:	
Dept:		Email:	
Tel No:		Mobile No:	

Is client aware of this referral:	**Y**		**N**	

Clinician Involved (Name)		**Role**		**Tel No**	

Do you consider there are any risks associated with this client?	**Yes**		**No**	

If Yes please specify:	

Current wheelchair user?:	**Y**		**N**		If **Yes** Is it an **NHS chair**	**Y**		**N**	

How often is/will the chair be used:

All day		Each day		5 days a week		3 days a week		1 – 2 days a week		Fortnightly		Monthly		Less than monthly	

When did you get your current chair?	**Date:**		**Are you entitled to DLA**	**Y**		**N**	

Please specify the type of chair you have:	

Manual Self Propelling		Manual Attendant controlled		Indoor Powered		Indoor/Outdoor powered		Voucher chair	

Diagnosis and Reason For Referral:

Are there any Special Considerations? ***(please enter U for Urgent or N for Non Urgent in each box)***

Palliative		Falls		Pain		Pressure Ulcers (past or present)	

To aid hospital Discharge		Date of Discharge:	

Which type of wheelchair or accessory is being considered?

Manual Self Propelling		Manual Attendant controlled		Indoor Powered		Indoor/Outdoor powered		Voucher chair	

Specialist Assessment required? i.e. Complex wheelchair postural seating needs..	

Accessories:	Cushion		Other (specify)	