Guidance Notes for the Completion of the WestMARC Adult Manual Wheelchair Referral Form

This document has been designed to assist you in completing the WestMARC Adult Manual Wheelchair Referral Form. The aim of this document is to help referrers to give WestMARC the most accurate and relevant information about their client. This will help us to provide your client with the most appropriate chair in the minimum amount of time. This form is intended for new patients (please see Reporting Form for existing patients).

This referral should be completed with an understanding of the NHS Scotland Wheelchair Eligibility Criteria - https://www.retis.scot.nhs.uk/wheelchaircriteria

The information you provide in the form will be used to determine the most appropriate pathway for your client; therefore, it is in your client's best interests for you to complete all sections of the referral form as fully as possible and ensure that all information provided is accurate.

The Manual Wheelchair Referral Form must be completed in full or the referral will be rejected.

Section 1: Client Details & Section 2: Alternative Contact Details

Please provide all requested demographic details and include up-to-date telephone number(s).

Please include an up-to-date height and weight for the client as a standard wheelchair may be prescribed and issued directly based on these dimensions. If using imperial measurements, please use standard notation e.g. 5' 8" (for five feet and eight inches) and 8st 3 lbs (for eight stone and three pounds).

Section 1: Client Details

Title:	Miss	CHI number:	02-02-42-2222
Forename(s):	Mary	Surname:	Smith
Date of birth:	02/02/1942	Sex:	Female
Tel (home):	0141 123 4567	Tel (mobile):	07123456789
Email:	marysmith@btinternet.com		
Height:	5'2" cm ☐ feet/inches ☉	Weight:	84 kg ☉ stone/pounds ☐

Home address & postcode:	22 Glasgow Avenue, Glasgow Postcode: G2 2MS
Delivery address & postcode:	33 Glasgow Crescent, Glasgow Postcode: G51 4TF
Communication requirements: e.g. Interpreter, communication via carer, prefers email contact.	None

Section 2: Alternative Contact Details (e.g. care worker, family member*)

Not applicable - contact client directly using details above ☐

Name:		Relationship to client:	
Telephone:		Email:	

*** Please refer to Section 8 to confirm client consent**

Section 3: GP Details

Please include all of your client's current GP information.

Section 3: GP Details			
GP Practice name:	Govan Health Centre	GP practice number:	12345
Telephone:	0141 205		
Surgery/practice address & postcode:	Govan Road, Glasgow, G51 3ED		

Section 4: Priority

As stated on the form we reserve the right to reassess urgency.

Urgency is assigned to clients with a rapidly degenerative and changing condition such as Motor Neurone Disease (MND) and clients with a palliative condition.

Discharge priority will only be given where the wheelchair will enable independent mobility or reduce a care package.

Please note that clients can sometimes be discharged home without a wheelchair.

Section 4: Priority		
Is this an urgent referral?	◉	No
We reserve the right to reassess urgency.	○	Yes: the client has a rapidly degenerative or palliative condition
* Discharge priority will only be given where the wheelchair will enable independent mobility or reduce a care package.	○	Yes: equipment is required for discharge from acute care*
Details of discharge date and location:	Discharge date set for 24th December Client being discharged to home address.	

Section 5: Clinical Information

Diagnoses:

Please include as much information as possible about client's all known conditions including primary condition and previous medical history. Please describe how your client is affected by their diagnosis. Please do not use abbreviations.

History of Pressure Ulcers:

Please provide as much information as possible regarding pressure issues either historical or current – this will help our team to decide if any additional clinical assessments will be needed prior to provision. If 'yes' is selected on the form please state the grade, location and size of the pressure sore(s):

Also include details of current pressure care management plan:

Please state if the client is capable of sitting in a standard chair unsupported.

If 'yes' is selected we will use client's height and weight to determine size of wheelchair client requires and this will be directly issued to the client.

If 'no' is selected please describe the presenting issues:

The reason we ask how a client can sit in a chair is to determine whether further support is required in the wheelchair i.e. postural supports, headrest etc. Please provide us with as much information as possible regarding patient's posture when seated. Examples include leaning to one side and sliding down in the chair.

Please note that if a client is bed bound we are unable to assess for wheelchair provision until suitable static seating is in place, a graded seating programme has been implemented and your client is getting up to sit safely on a daily basis.

Section 5: Clinical Information

Diagnoses: Please include all known conditions. Please do not use abbreviations.	Client was diagnosed with multiple sclerosis in 2019. Client also has type 2 diabetes and high blood pressure.
Does the client have a history of pressure ulcers?	☐ No ☑ Yes, with current pressure ulcers ☐ Yes, historical only
If 'yes' for historic or current ulcers, please state location and grade:	Client has grade 3 pressure sore on her right buttock. This sore currently measures 3cm wide by 1cm long.
Detail current pressure care management plan:	District nurses visit every 2nd day to review, clean and dress the wound. Cline thas been advised to only get up to sit for 1 hour every day on 2 separate occasions.
Is the client capable of sitting in a standard chair unsupported?	☐ Yes ☑ No
If 'no', please describe issues (e.g. skeletal deformity, muscle contracture, bedbound, significant pain, balance issues affecting sitting)	Clients condition has deteriorated and she now presents with reduced trunk control whereby her trunk falls to the left hand side. Client slides down when sitting and is unable to adjust her position. Client tends to sit in posterior pelvic tilt with her left hip in external rotation and her feet in plantarflexion.

Section 6: Requested Equipment

Current functional ability:

Please describe client's current mobility state – do they use a walking aid?

Please describe client's current transfer ability – do they transfer unaided or do they require assistance from equipment such as a standaid or hoist?

Factors affecting use of Wheelchair Indoors:

Please describe client's home environment and any restrictions that might affect the use of a wheelchair indoors including narrow doorways, internal steps, cluttered rooms and tight turning circles.

Please note that we provide a wheelchair to fit the patient not to fit the environment so adaptation to the home environment may need to be considered either prior to or following wheelchair provision. Please ensure you have discussed the type of propulsion (i.e. attendant or occupant propelled) with the patient before making the referral.

Occupant Propelled Wheelchair is a chair with large rear wheels to allow the client to self-propel and manoeuvre the chair independently. The client must be medically and physically fit to do this.

Attendant-propelled Wheelchair is a chair with small rear wheels and the client requires to be pushed in this by a family member, friend or carer. The user would be unable to propel this themselves.

All of our wheelchairs come with a lap strap and cushion.

Please also note that if your client is provided with an occupant propelled wheelchair (large rear wheels) and changes their mind following delivery of the chair we will not swap the chair over, as this chair can also be used as an attendant-propelled wheelchair.

If your client resides in a Care Home and requires a standard attendant-propelled wheelchair please note that they do not meet the criteria for wheelchair provision, as it is the Care Home's responsibility to provide a pool of wheelchairs for their residents to access and use.

Measurements:

These need to be as accurate as possible to prevent a chair of the wrong size being delivered. Many of our clients are directly issued a wheelchair without being seen by a clinician. If the measurements are inaccurate your client may receive an unsuitable wheelchair that may place them in discomfort or pain or increase their risk of pressure sores.

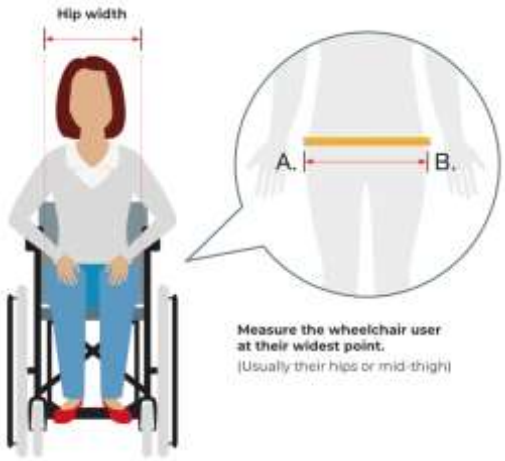
All measurements should be taken with the person in a SEATED position wherever possible. If this is not possible,please indicate on the form e.g. “measurements taken lying down”. For all of the measures below the measuring tape should be kept as taut as possible, ideally using a metal measuring tape.

A Hip Width – Measured across the hips. This is a straight line measurement and does not conform to their body shape. This lets us determine the seated width of the wheelchair.

B Upper Leg – This is the measurement from the back of the bottom to behind the knee when seated. It is used to calculate the required seat depth.

C Lower Leg – This measurement is taken from immediately behind the knee to the client’s heel when their foot is place flat (if possible) on the floor or footplate. It is used to calculate the required height of the footrests and seat height.

D Base to top of shoulder – This measurement is taken from the seated surface to top of shoulders.



Section 6: Requested Equipment

Current functional ability:

Please include - mobility, use of daily living aids, static seating, transfers, etc.

Client is no longer mobile and is hoisted for all transfers. Client sits in specialist tilt-in-space armchair in her home.

Detail any known factors potentially affecting use of a wheelchair indoors:

e.g. narrow doorways, steps, steep access, insufficient turning circles, etc

Client lives in a fully wheelchair accessible and adapted ground floor flat with ramped access at the front door.

Please refer to our website section 'Wheelchair Referral Guidance' which will provide guidance on selecting which size of wheels and type of chair is most appropriate.

This referral is for:

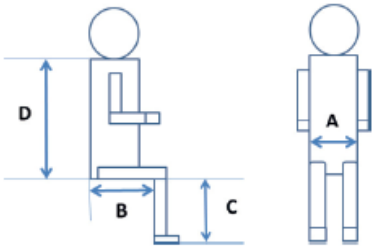
☐ Occupant-propelled wheelchair (large wheels).

Client must be medically fit to self-propel.

☉ Attendant-propelled wheelchair (small wheels).

If your client lives in a care home and requires a standard attendant-propelled wheelchair, it is the care home's responsibility to provide a pool of wheelchairs for their residents to access, and this referral will be declined.

Patient dimensions (optional) - refer to measurement guidance on website



A - Hip width in sitting position:	17
B - Upper leg, back of buttocks to back of knee:	17
C - Lower leg, back of knee to sole of foot:	17
D - Base to top of shoulder:	17

Units of measurement used: ☐ cm ☉ feet/inches

Section 7: Further supporting information

Please include any other relevant clinical or environmental information.

Please indicate any other issues we should be aware of that might affect the wheelchair we provide and how it is used, e.g. Adult Support and Protection Issues.

Section 7: Further supporting information

Client has experienced a significant deterioriation in her physical health resulting in recent hospital admission and stay for 3 weeks.

Client is no longer mobile and will require a suitable wheelchair for all of her mobility needs.

Client lives with her husband who continues to work full time. Client is in the process of employing a personal assistant who will help her attend medical appointments and engage in social activities to improve her quality of life.

Section 8: Client Capacity and Consent

Please state if your client has the capacity to consent to the referral being made and any subsequent intervention.

If your client does not have capacity to consent please tell us who has legal rights, such as guardianship or power of attorney, to consent on the client's behalf. This could be a spouse, family member or Social Worker.

Section 8: Client Capacity and Consent		
Does your client have capacity to consent to intervention?	☒ Yes	☐ No
If your client does not have capacity to consent, please confirm who has legal rights to consent on the client's behalf.		
Does your client consent to this referral?	☒ Yes	☐ No
If no, state why the referral is in your client's best interests		
Does your client consent to us sharing information with you?	☒ Yes	☐ No

Section 9: Referrer Details

This form must be completed by a Healthcare Professional or Social Worker registered with one of the following bodies:

- Health and Care Professions Council
- General Medical Council
- Nursing and Midwifery Council
- Scottish Social Work Council

The Manual Wheelchair Referral Form must be completed in Full or the referral will be rejected.

Section 9: Referrer Details

This section must be completed in full, or your referral will be rejected.

☑ By checking this box I confirm that I have read and understood the eligibly criteria and associated information on the website

Referrer name:	John Smith	Position:	OT
Telephone:	0141 765 4321	Mobile:	07987654321
Professional registration number:	OT12345		
Email:	john.smith.OT@nhs.scot		
Work address and postcode:	Queen Elizabeth University Hospital, 1345 Govan Road, Glasgow	Postcode:	G51 4TF

Please indicate the best method of contact and your working hours should we require to contact you for further clarification:

I currently work full time Monday to Friday from 8pm to 4pm.
Please contact me by email as I am often out of the office on home visits.

Please save this form in PDF format and email a copy to: ✉ westmarc@ggc.scot.nhs.uk