NHS Greater Glasgow and Clyde

WestMARC Paediatric Wheelchair, Buggy and Seating Initial Referral Form *(for all children under 16 years old)*

Main office: WestMARC, Queen Elizabeth University Hospital Campus, 1345 Govan Road, Glasgow, G51 4TF

☎ **0300 790 0129** ✉ ggc.westmarc@nhs.scot

- This referral should be completed with an understanding of the NHS Scotland wheelchair eligibility criteria (🌐 https://www.retis.scot.nhs.uk/wheelchaircriteria) and having read the guidance on the WestMARC website (🌐 http://www.nhsggc.scot/westmarc)

  ☐ I confirm that I have read the eligibility criteria and this is an appropriate referral.

  ☐ I confirm the chair will be required for 6 months or more.
- New referrals must be made by a healthcare professional or social worker registered with one of the following bodies; Nursing and Midwifery Council, Health and Care Professions Council, General Medical Council, or Scottish Social Work Council.
- This form must be completed in full. Failure to do so will result in your referral being delayed, or rejected. Please write information in full and do not use abbreviations.
- **Please note all referrals requesting equipment for children with neurodevelopmental differences and no underlying physical health condition will only be considered when a child is aged 6 and over. These referrals will be screened by a member of the paediatric team and will be rejected if alternative strategies have not been tried prior to making a referral. Please refer to the Mobility and Neurodevelopmental Differences document for further information** (🌐 https://www.nhsggc.scot/downloads/neurodevelopmental-differences-document/)




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Section 1: Child Details

Title:		**CHI number:**	
Forename(s):		**Surname:**	
Date of birth:		**Gender:**	
Tel (home):		**Tel (mobile):**	
Height:	cm ○ feet/inches ○	Weight:	kg ○ stone/pounds ○

Home address & postcode:

Postcode:

School/Nursery address & postcode:

Postcode:

Delivery address, postcode and telephone (if different):

Parent/Guardian Details:
include Relationship to child and email.

Communication requirements:
e.g. Interpreter, communication via carer, prefers email contact.

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Section 2: GP Details

GP Practice name:		GP practice number:	
Telephone:			
Surgery/practice address & postcode:			

Section 3: Child's MDT Details (e.g. Orthopaedics, Neurology, Neurosurgery, Paediatrician)

Name	Profession	Email address

Section 4: Priority

Is this an urgent referral?

We reserve the right to reassess urgency.

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

- ☐ No
- ☐ Yes: the child has a rapidly degenerative or palliative condition
- ☐ Yes: equipment is required for discharge from acute care*

Details of discharge date and location:

Detail any other reason that you might consider this an urgent referral:

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Section 5: Clinical Information

Diagnoses:
Please include all known conditions.
Please do not use abbreviations.
Please include Gross Motor Function Classification System (GMFCS) Score if known

Hearing, visual, communication ability

Previous/ planned surgical intervention

Any other relevant clinical information e.g. postural issues, muscle tone, range of movement limitations, pressure ulcers. If referring for a powered wheelchair, please include information on seizure activity/blackouts within the last 12 months

Neurodevelopmental differences: If you are referring a child with neurodevelopmental differences, who is aged over 6, and you are requesting a device solely as a form of physical restraint*, please list alternative strategies which have been tried to minimize and prevent use of restraint prior to referring to WestMARC. Please provide time scales for these interventions.

* Physical restraint can be classified as any device/equipment intended to prevent the child from carrying out an intentional task, even if deemed unsafe i.e. running away, lack of road safety, dropping to the ground etc.

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Section 6: Requested Equipment

Current functional ability:

Please include - mobility, use of daily living aids, static seating, sleep system, transfers - at home and school/nursery.

Please detail local therapy aims that may impact on provision (transfers independent aids, regulation strategies)

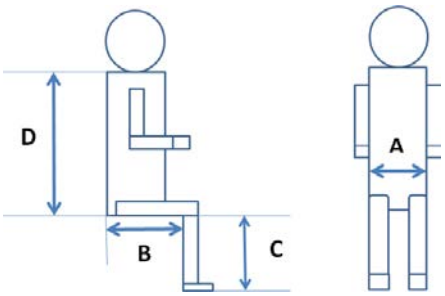
Detail any known factors potentially affecting use of a wheelchair indoors:

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

This referral is for:

- ☐ Occupant-propelled wheelchair (large wheels).
- ☐ Attendant-propelled wheelchair (small wheels).
- ☐ Postural support buggy
- ☐ Standard buggy
- ☐ Special seating
- ☐ Active user/Energy efficient wheelchair
  Please refer tothe eligibility criteria for active user wheelchair provision
- ☐ Powered wheelchair provision
  Please refer to the eligibility criteria for powered wheelchair provision

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



A - Hip width in sitting position:

B - Upper leg, back of buttocks to back of knee:

C - Lower leg, back of knee to sole of foot:

D - Base to top of shoulder:

Units of measurement used: ◯ cm ◯ feet/inches

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Section 7: Further supporting information e.g. Social work involvement, Child Protection

Section 8: Client Capacity and Consent

Has the child's parent/guardian given consent to this referral? ☐ Yes ☐ No

If no, state why the referral is in the child's best interests

Does the child's parent/ guardian consent to us sharing information with you? ☐ Yes ☐ No

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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:		Position:	
Telephone:		Mobile:	
Professional registration number:			
Email:			
Work address and postcode:			
Preferred method of contact and working hours.			

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