ADULT WHEELCHAIR REQUEST FORM

WestMARC
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HOW THIS FORM WORKS

This form must be completed for adult patients with a permanent disability who are Referred for the first time for a wheelchair / special seating system (including Wheelchair cushions). It should also be completed for existing wheelchair users for Whom an assessment for a power chair is being requested.

PLEASE NOTE

- A Paediatric Wheelchair Form should be used for those under 15 years of age
- A Reporting Form should be used for existing wheelchair users who require revision of their manual issue e.g. change of seat size, modification, accessories

In order to prevent unnecessary delays it is important that the relevant sections of the form be completed accurately. Sections A, B and either C or D (depending on the type of) Wheelchair being requested) should be fully completed in consultation with the patient or their carer. Finally, Section E **must** be signed by **a GMC, NMC or HPC registered healthcare professional.** The form will be returned to the referrer if any of the above mentioned sections have not been fully completed.

SECTION A

(this section must be completed for all patients)

CLIENT SURNAME:..... ADDRESS:.....

FORENAMES: ....

DATE OF BIRTH:..... .....

CHI NO:..... POSTCODE:.....

TEL. NO.....

Patients GP's Name:..... Delivery Address (if different)

....

Postcode.....Tel. No. ....

Practice Code:..... TEL. NO.....

Does the patient already have a NHS wheelchair? **YES** ☐ **NO** ☐

ADULT WHEELCHAIR REQUEST FORM

SECTION B

(about the patient)

1. **Main diagnosis/disability**:……

2 . **Other significant diagnoses or disabilities**:……

……..

3. **Does the patient require a standard foam cushion?** YES ☐ NO ☐

Does the patient have a high risk of pressure problems? YES ☐ NO ☐

If yes, **state reasons:**……

Do you wish the patient to be assessed for a pressure relieving cushion? YES ☐ NO ☐

Please note that "pressure relieving" cushions do not prevent pressure sores. At best, the allow a small increase in the safe sitting time between changes of position for pressure relief.

4. **Does the patient have postural or other problems which would require special seating provision?** YES ☐ NO ☐

If yes, please give further details. (Patient may require formal assessment by one of our staff Either in the community or alternatively at a clinic in Westmarc.)

……..

5. **Patients: HEIGHT…… WEIGHT……**

Please note that wheelchairs cannot be provided without this information

SECTION C

(complete if a **manual** wheelchair is required)

1. **Will the wheelchair be propelled by:** patient? ☐
   attendant ☐
   both ☐

2. **Will the wheelchair be transported in a car?** YES ☐ NO ☐

If yes, give details of car type:……

ADULT WHEELCHAIR REQUEST FORM

SECTION D

(complete if an **electric** wheelchair required)

Electric wheelchairs are available through the NHS to those patients who's **indoor** mobility is severely impaired. In order to be eligible for such a chair, the patient must be **unable to walk safely indoors** and **unable to self propel a manual chair indoors.** Please note that electric wheelchairs are not issued to patients simply because they have difficulties with their mobility indoors. Once a patient has been deemed eligible for an electric chair based on their limited **indoor** mobility, the assessment procedure will consider whether an indoor OR outdoor electric chair would be more appropriate.

In your opinion is the patient:-

- Unable to walk safely indoors? YES ☐ NO ☐
- Unable to self propel a manual wheelchair indoors? YES ☐ NO ☐
- Capable of understanding the uses, control and safety Issues applicable to an electric wheelchair? YES ☐ NO ☐

If the answer to the above questions are all YES it would be appropriate to refer the patient for assessment for an electricity powered wheelchair – if you would like to do this please tick box: ☐

SECTION E

Is there any additional information you think WESTMARC should know which is not covered so far e.g. need for urgency? Please use this space to give relevant information/explanations:

SECTION E (continued)

HEALTHCARE CONTACTS: please indicate who filled in the form:

HOSPITAL DOCTOR ☐ GENERAL PRACTITIONER ☐ PHYSIO ☐

THERAPIST (O/T) ☐ OTHER (state)……..

Name:…… Address:……

Tel.No.:…… ……

This section must be completed / signed by one of the following:

a GMC, NMC or HPC registered healthcare professional

Signature:…… Name:……..

Designation:…… Address:……

Tel.No: …… ……

Date:…… Postcode:……

FOR WESTMARC USE ONLY

Uni	☐	15 x 16”	☐	12.5”	☐	2”	☐
Access	☐	17 x 17”	☐	22”	☐	3”	☐
Heavy Duty	☐	19 x 17”	☐	24”	☐	4” Modular	☐
AMP Setup	☐			24” QD	☐	Silicone seat pad	☐

Other prescriptions:

Adaptations:

Lap strap ☐ Stump Board R ☐ L ☐ Extended Brake Leaver R ☐ L ☐

Assessment: **Clinic:**

TO ☐ **OT** ☐ **Power chair** ☐ **General** ☐

Signature:…….. Date……