WestMARC Adult Manual Wheelchair Referral Form

NHS Greater Glasgow and Clyde

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

☎ 0300 790 0129

- 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 guidance on WestMARC website: 🌐 www.nhsggc.scot/westmarc
- New clients must be referred 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.

Section 1: Client Details

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

Home address & postcode:

Postcode:

Delivery address, postcode and telephone:

Tel (delivery) Postcode:

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

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

GP Practice name: | GP practice number:

Telephone:

Surgery/practice address & postcode:

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 client has a rapidly degenerative or palliative condition
- ☐ Yes: equipment is required for discharge from acute care*

Details of discharge date and location:

Section 5: Clinical Information

Diagnoses:

Please include all known conditions. Please do not use abbreviations.

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:

Detail current pressure care management plan:

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)

Section 6: Requested Equipment

Current functional ability:

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

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

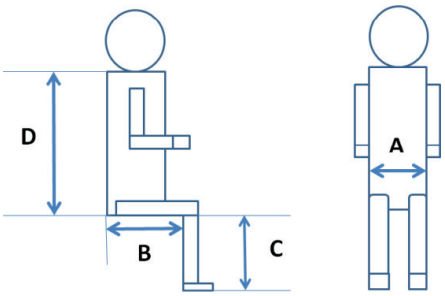
e.g. narrow doorways, steps, steep access, insufficient turning circles, etc

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:

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

Section 7: Further supporting information

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 (or their representative) 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 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:

Postcode:

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

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