Westmarc

Children's Wheelchair, Buggy and Seating Referral Form

This form must be completed for children under 16 years of age with a disability who require a buggy, wheelchair or specialist seating. Please ensure that all essential sections (*) of this form are completed. Incomplete and unsigned forms may not be accepted and could delay provision.

*Patient

Surname:	Home address:	
Forename(s):		
DOB/CHI Number:		
Sex:	Postcode:	
	Tel. no:	Other tel. no:
Delivery address and contact (if different):		

General Practitioner

*Name:	
*Address:	
Postcode:	
*Tel:	GP Practice code:

School/Day Centre (if applicable)

*Name:
*Address:
Postcode:
Tel:

Referrer (consent for referral must have been obtained from parents/guardian)

*Name:	Address:
*Profession:	
*Signature:	Postcode:
*Date:	*Tel:
	Email:

Clinical information

*Primary diagnosis:
Any other **relevant** clinical information:

Please indicate the type of chair you feel child will require (#please refer to eligibility criteria)

☐ Postural support Buggy
☐ Buggy
☐ Attendant propelling chair
☐ Special Seating
☐ Self propelling manual chair
☐ Energy efficient wheelchair
☐ Power provision

If you have undertaken Westmarc training- can a standard buggy/wheelchair be issued without assessment? If yes please complete measurements below (there is no need to complete page 2 in this instance).

Pelvic width (mm)	Seat depth (mm):	Lower leg Length (mm)
	Height:	**Weight:**

To be completed if patient requires a Clinical assessment

Clinical Information

Hearing / visual / communication ability, include first language if not English:
Details of relevant previous / planned medical or surgical information (including dates):
Details of relevant skin care / pressure sore problems (including dates):
Description of fixed deformities, limitations in ranges of joint motion and abnormal muscle tone (please include recent relevant assessment if available) :
GMFCS Score if known:

Wheelchair and seating provision

*Reason for referral (please specify wheelchair):
*Postural management arrangements at home and school:
Local therapy aims that may impact on provision: e.g transfers, independent mobility, communication aids:

Other Health Professionals involved e.g. OT, Physio

Profession:	Profession:
Name:	Name:
Address:	Address:
Postcode:	Postcode:
Tel:	Tel:

Any other relevant information

e.g family circumstances, housing:

Please post to:
Westmarc, Southern General Hospital, 1345 Govan Road, Glasgow G51 4TF
Tel: 0844 811 3001 Email: westmarc@ggc.scot.nhs.uk

Westmarc Use Only:

Signature: ______________________ Date: ____________

MIS 257923