NHS Greater Glasgow and Clyde

WestMARC Wheelchair, Buggy and Seating Reporting Form

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

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

This form is intended for all **existing** clients (please see the Manual, Power or Paediatric referral form for new clients). This form can be completed by a Health Care 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 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 www.nhsggc.scot/westmarc

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 Reporting Form must be completed in full. Failure to do so will result in it being delayed, or rejected. Please write information in full and do not use abbreviations.

NHS Greater Glasgow and Clyde

Is this an urgent referral **Yes** ☐ **No** ☐

If yes, please provide reason in the text box in section 4

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 4 to confirm client consent**

Section 3: Clinical Information

Diagnoses:

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

NHS Greater Glasgow and Clyde

Section 4: Consent, Equipment, Reason

Has your client / parent or guardian / legal representative given consent to this referral?

Yes ☐ **No** ☐

Please select what equipment this reporting form is regarding:

Other

Reason for referral

Other

Please provide all relevant information for this referral below:

NHS Greater Glasgow and Clyde

Section 5: 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