WHEELCHAIR REQUEST FORM

WESTMARC

Southern General Hospital NHS Trust
1345 Govan Road
GLASGOW
G51 4TF
TELEPHONE NUMBER:- 0141 201 2620

HOW THIS FORM WORKS

This form must be completed for those patients **with a permanent disability** who require a wheelchair/buggy or special seating (including wheelchair cushions). In order to prevent unnecessary delays it is important that relevant sections of the form be completed accurately. Sections A, B and either C or D (depending on the type of chair being requested) should be completed in consultation with the patient or their carer. Finally, Section E of the form **must** be signed by the patient's General Practitioner, Hospital Doctor or WESTMARC approved prescriber.

SECTION A

(this section must be completed for all patients)

CLIENT SURNAME ……..
FORENAMES ……..
DATE OF BIRTH ……..
PATIENT'S GP NAME ……..
ADDRESS ……..
……
POSTCODE …… TEL NO. ……..
PRACTICE CODE ……..

ADDRESS ……..
……
POSTCODE ……..
TEL NO. ……..
DELIVERY ADDRESS (if different)
……
……
……
TEL. NO. ……

Does the patient already have a wheelchair? Yes ❒ No ❒

IN ORDER TO FACILITATE THE PROCESSING OF THIS REQUEST PLEASE INDICATE BELOW PATIENT'S AGE GROUP AND THE TYPE OF CHAIR REQUIRED:

0 – 12 years of age ❒	Buggy	❒
13 years and over ❒	Self propelling manual chair	❒
	Attendant propelling manual chair	❒
	Electric wheelchair	❒

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 cushion?

   Yes ❒ No ❒

   Please note that "pressure relieving" cushions do not prevent pressure sores. At best, they 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. (The patient may be required to attend a clinic or a Medical Technical Officer will visit to assess).

   ……

5. **Patient's HEIGHT** …… **WEIGHT** ……..

   please note that wheelchairs cannot be provided without this information

SECTION C

(complete if a standard wheelchair required)

1. **Will the wheelchair be propelled** by patient ❒
   attendant ❒
   both ❒

2. **Will the wheelchair be transported in a car?** Yes ❒ No ❒

   Is yes, give details of car type ……

SECTION D

(complete if an electric wheelchair required)

Electric wheelchairs are issued according to the following criteria which have been ratified by the Scottish Office. If you patient meets one of these criteria please tick the appropriate referral space. **Please note:** local topography cannot be taken into account when considering EPIOC/EPOC requests.

WHEELCHAIR REQUEST FORM

EPIC ❒ occupant controlled indoor use
patients must be unable to walk safely or self propel a standard wheelchair **indoors**

EPIOC ❒ occupant controlled indoor/outdoor use
Patients must be unable to walk safely or self propel a standard wheelchair indoors **plus** meet specific requirements regarding awareness of environment, epileptic seizures and eyesight similar to those for a standard driving licence
PLEASE NOTE patient must require the use of a powered chair inside and outside the house

EPOC ❒ attendant controlled outdoor
The patient must require regular use of a wheelchair and the main carer must be precluded from pushing the patient in a standard non-electric wheelchair due their own disability, ill health or because of a considerable weight different. (In this instance the patient should normally weigh in excess of 16 stone/100Kg. A **medical certificate** must be supplied to this effect prior to assessment.

1. **Mental ability**

Is the patient/carer capable of understanding the uses, control and safety issues applicable to a powered wheelchair? Yes ❒ No ❒

2. **Spatial awareness and co-ordination**

Has the patient/carer an adequate level to control la wheelchair? Yes ❒ No ❒

3. **visual acuity** (with glasses if appropriate) ……

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.

Please tick one of the following boxes to show how this patient could travel to clinic should a formal assessment be required

Own Transport	❒	Ambulance Car	❒	Ambulance (one man)	❒
Unable to Travel	❒			Ambulance (two man)	❒

If ambulance requested place state the **medical reason** why this is required?

……

WHEELCHAIR REQUEST FORM

HEALTH CARE CONTACTS: please indicate who filled in the form:

Hospital Doctor ❒ General Practitioner ❒

Therapist (OT) ❒ (Phsyio) ❒ Other (state) ……..

Name …….. Address ……..

……. Tel. No. ……

This section must be completed/signed by the patient's General Practitioner, Hospital Doctor or Westmarc prescriber.

Signature …….. Name …….. Date ……

Designation …….. Address ……..

Phone no. …….. ……

……

Postcode ……

FOR WESTMARC USE ONLY

Scott/Uni ❒ Heavy Duty ❒

Dimensions of seat
15x16" ❒ 16x16" ❒ 17x17" ❒ 19x17" ❒

Specification of wheel
12.5" ❒ 22" ❒ 24" ❒ QD ❒

Cushion
2" ❒ 3" ❒ 2" modular ❒ 4" modular ❒ silicore seat pad ❒

Adaptations
Lap strap ❒ stump board R ❒ L ❒ extended brake lever R ❒ L ❒

Other

For assessment:
Technical Officer ❒ Occupational Therapist ❒ Call to Clinic ❒

Signature …… Date ……