The Posture & Mobility Service

Referral Form

South Wales
ALAS Posture & Mobility Centre
Unit 1 Taffs Fall Road
Treforest Industrial Estate
Pontypridd
CF37 5TT
Tel: 02921 848100

For help in completing this form and other information
www.alas.wales.nhs.uk

North Wales
Posture & Mobility Service
Croesnewydd Road
Wrexham
LL13 7NT
Tel: 03000 850055
Fax: 03000 857231

Important - please read

The information you provide shall be used to determine the most appropriate pathway for your client. It is in your client's best interest for you to complete all sections of this referral as fully as possible and that all information provided is accurate.

You must complete all sections marked in **GREEN** - Incomplete forms will be returned unprocessed.

If you require help in completing this form, please contact the service on the number above or visit our website on www.alas.wales.nhs.uk.

Eligibility Criteria

The service only accepts referrals which meet the NHS criteria for the provision of essential posture and mobility equiment. However, the service does strive to meet the lifestyle needs in the course of providing essential posture and mobility requirements. All new referrals to the service must be made by a registered health and social care professional with the appropriate knowledge and skills.

All referrals to the service must meet the following criteria:

- The client is permanently resident in Wales or registered with a GP practice that is in Wales and who lives within an English commissioner area bordering Wales.
- The client has a permanent physical impairment or medical condition that affects their ability to walk and will need a wheelchair for more than 6 months.

There are no exceptions to the first criterion. Exceptions to the second criterion include clients with rapidly deteriorating life limiting conditions.

For short term loan, please refer to other agency (e.g. British Red Cross)

How we process your referral	The posture and mobility service is unable to provide
Stage 1 - Referral Acceptance When we receive your referral it will be thoroughly checked for completeness and accuracy. Your referral will be accepted once we are satisfied that it meets our criteria standards. **Stage 2 - Screening and Categorisation** Accepted referrals will be categorised as either Non Complex or Complex. **Non Complex** - require no further assessment, prior to the delivery of equipment. **Complex** - Our assessment team will look at your referral in detail and will then decide to either prescribe equipment, based on the details you have provided, or to list your client for an assessment. During this stage it may be necessary to contact you for additional information.	▪ Wheelchairs/buggies for use as a restraint or as a static chair ▪ Standard attendant wheelchairs to Residential or Nursing Homes for moving and handling purposes only ▪ Tilt-in-space wheelchairs for restraint purposes, (e.g. to keep clients in the seat when they have volitional movement) ▪ Cushions for armchairs or seating other than a wheelchair ▪ Class three vehicles ▪ Mobility scooters

Is your client already registered with our service? No ◯ Yes ◯ Don't know ◯ Our reference number if known

Preferred language and communication needs

NHS number

A	**Client's details**	
1	**Date of birth**	
2	**Title**	If the title you want doesn't appear in the list you can type in your own.
	Surname	
	Forename	
	Middle name(s)	
	Suffix	
	Known as	
3	**Has client ever been known by any other name?**	No ◯ Yes ◯ If **'Yes'**, please complete question 4. If **'No'**, go to question 5.
4	**Title**	If the title you want doesn't appear in the list you can type in your own.
	Surname	
	Forename	
	Middle name(s)	
	Suffix	
	Known as	
5	**Does client live alone?**	No ◯ Yes ◯
6	**Current address**	**House Name/Site**
		Number / Street
		Line 1
		Line 2
		Line 3
		Town
		County
		Postcode
7	**Telephone 1**	This is the number we will use to contact the client
8	**Telephone 2**	
9	**Email**	
10	**Is this the client's usual day time address?**	No ◯ Yes ◯ If **'Yes'**, then this is the address we will use for delivery. Now go to 14. If **'No'**, then please complete 11-13.

11	Type		
12	Usual address	House Name/Site	
		Line 1	Number: Street:
		Line 2	
		Line 3	
		Town	
		County	
		Postcode	
13	Telephone		
14	**Is client currently in hospital?**	No ◯ Yes ◯	If **'Yes'**, please complete 15-17. If **'No'**, then go to section **B - Other Contacts**.
15	Hospital name & ward		
16	Hospital telephone		
17	Expected discharge		

B Other contacts

Please use this section to let us know of any other contacts for this client. If none then go to Section C

		Contact number	Contact name	Relationship to client	Next of kin
18	Contact 1				
19	Contact 2				

C Primary reason for referral

20 Please describe the primary reason you are referring this client for a wheelchair (i.e. What need will the wheelchair and seating address?)

21 Please read the descriptions and select the box that best describes the client

Limited walking - part time wheelchair user

- ◯ Regular need for wheelchair for outdoor use
- ◯ Consistent need for wheelchair indoors and outdoors

Unable to walk - full time wheelchair user

- ◯ Low activity - limited ability to self propel
- ◯ Restricted activity - unable to self propel
- ◯ High activity - independent lifestyle able to self propel indoors and outdoors or uses a powered wheelchair

D Contraindications

22 Does client suffer from epilepsy or other seizures? No ◯ Yes ◯ If **'Yes'**, please complete **23**. If **'No'**, then go to **24**.

23 Please provide date of last seizure or select the box to confirm seizure-free for more than 12 months

Seizure-free for more than 12 months ☐

24 Does client wish to push themselves (self propelling wheels)? No ◯ Yes ◯ If **'Yes'**, please complete **25**. If **'No'**, then go to **26 - Medical History**.

Self-propelling wheels

25 Does client have any condition that may contraindicate this? (e.g. cardio-respiratory)

No ◯ Yes ◯ If **'Yes'**, then please ensure the condition is included in **26 - Medical History**.

PLEASE NOTE If you are not the client's GP, we may need to confirm whether your client is medically fit to self propel before we can continue. If you are able to provide written confirmation from the GP with this referral, then this could reduce the length of time your client waits.

E Medical history

26 Please list the permanent physical impairments or medical conditions that affect the client's ability to walk

27 Please describe your client's medical condition, including the effects on posture and mobility.

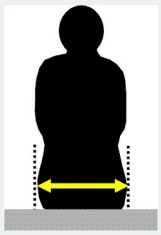
F Measurements

Accurate measurements are essential for us to provide suitable equipment and/or to determine the most appropriate pathway for your client. Incorrect or 'estimated' measurements could cause unnecessary delays to the process.

28 Sex Male ◯ Female ◯

	Centimetres (cm)	Feet (ft)	Inches (ins)
29 Height			
	Kilograms (kg)	Stone (st)	Pounds (lbs)
30 Weight			

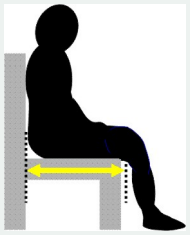
31 Hip Width



Measure across the widest point of the lower body, usually the hips or outer thighs

Centimetres (cm) Inches (ins)

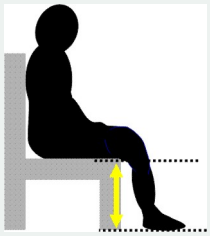
32 Upper leg length



Measure from behind the knee to the back of the buttock or sacrum

Centimetres (cm) Inches (ins)

33 **Lower leg length**



Measure from behind the knee to the bottom of the heel

Centimetres (cm) Inches (ins)

34 **If you require a wider chair than the hip width given, please give your reasoning**

G Posture and sitting

Does the client have any of the following conditions that would cause problems with sitting or using a standard wheelchair?

If 'Yes', please describe. (e.g. head control, restricted, fixed)

35 **Limited range of joint/limb movement which impacts upon their ability to sit?** No ○ Yes ○

(e.g. head control, trunk control)

36 **Abnormal posture?** No ○ Yes ○

Describe what happens over time (e.g. side lean, fall forwards, backwards or to the side, etc)

37 **Harness or additional postural support required to aid sitting?** No ○ Yes ○

Equipment request for managing behaviour will be subjected to a risk assessment

38 **Any other needs that cannot be met without accessories?** No ○ Yes ○

H Environment

(e.g. type of accommodation, step/lift to access, narrow doors, minimum turning circle, etc.)

39 **Please describe any limiting factors about your client's environment that we would need to consider**

I Type of wheelchair

We will screen every referral to decide what equipment we feel is most suitable for your client's needs and environment. However to give us some indication of the type of wheelchair that, in your professional opinion, your client would benefit from the most, please select from the options below.

40 **Type of wheelchair**

Non-powered ◯ Powered ◯ Buggy ◯

Criteria - Provided only for postural support
Buggies may be issued to children as an alternative to a wheelchair, where it best meets clinical and mobility needs and the following applies: Child is unable to walk distances and it is envisaged it will be required for 2 years and a shop bought buggy is not available for the child's weight or size.

J Ability to travel

41 **It may be necessary for our assessment team to see the client (see front page: How we process your referral). If so, is your client able to travel to one of our clinic locations?**

No ◯ Yes ◯

If '**No**', please explain why not

42 **If we do need to see the client, please use this space to let us know if there is anyone we should invite?**

K Transportation and transferring

IMPORTANT - In the interest of your client's safety we advise, if it is possible, to avoid sitting in a wheelchair in a vehicle. The standard seating in any vehicle should be used.

43 **Will your client need to travel in their wheelchair in a vehicle?**

No ◯ Yes ◯

44 **Will your client need to transport their wheelchair folded in the boot of a vehicle?**

No ◯ Yes ◯

45 **How does your client transfer?**

Independently ◯ Assisted ◯ Hoisted ◯ Sliding Board ◯

L Tissue viability

46 **Please read the descriptions and select the box that best describes the client**

◯ **No identified risk/low risk** - Part or full time user with ability to change position and transfer independently. Good general health, no past or current problems with skin integrity and able to comply with advice - Go to **56**

◯ **Medium Risk** - less able to transfer and is at risk of tissue breakdown due to a number of factors such as extended periods of sitting, variable health or a condition that would put client at risk - Complete parts **47 - 55**

◯ **High Risk** - Immobile, unable to change position. Has a history of or present with current pressure ulcers - Complete parts **47 - 55**

M **Pressure ulcers**

Please describe the pressure ulcers and associated risks by selecting the most appropriate answers

47 **Status**

Previous ◯ Current ◯ Potential ◯

48 **If a current pressure sore, is it dressed?**

No ◯ Yes ◯

49 **From**

Bed ☐

Wheelchair ☐

Other ☐ If other please specify

50 **At**

Home ☐

Hospital ☐

Other ☐ If other please specify

51 **Site**

Sacrum ☐

Ischial Tuberosity (R) ☐

Ischial Tuberosity (L) ☐

Greater Trochanter (R) ☐

Greater Trochanter (L) ☐

Other ☐ If other please specify

52 **Grade**

Fading redness ☐

Prolonged redness ☐

Broken skin ☐

Deep ☐

Involving bone ☐

53 **Treatment**

Medical ☐

Surgical ☐

None ☐

54 **Associated Risks**

Is the client continent? No ◯ Yes ◯

Is the client's position in sitting symmetrical? No ◯ Yes ◯

Is the client's sensation in sitting area Normal ◯ Partial ◯ Anaesthetic ◯

Is the client's posture in chair Upright ◯ Slumped ◯ Slips over time ◯

Is the client's nutrition Poor ◯ Adequate ◯ Normal ◯

Is the client's hydration Poor ◯ Adequate ◯ Normal ◯

55 **Current pressure relieving products**

◯ None If **'None'** go to 56, else please specify product type.

◯ Cushion

◯ Other

Reason this is not meeting the client's needs?

N Other details

If you think we should be made aware of any other information about your client, please use this space

56 For example, fit of current chair, problems with communication, special arrangements for delivery, any standard accessories etc.

General Practitioner and Referrer Details

O GP Details

57 Are you the client's GP? No ◯ Yes ◯ If **'Yes'**, then go to **62** If **'No'** then go to **58**

58 Title — If the title you want doesn't appear in the list you can type in your own.

Surname

Forename

Middle name(s)

Suffix

Known as

59 Practice Name

60 Address — House Name/Site

Number Street

Line 1

Line 2

Line 3

Town

County

Postcode

61 Telephone

P Your details (The referrer)

62 Accreditation number

63 Title — If the title you want doesn't appear in the list you can type in your own.

Surname

Forename

Middle name(s)

Suffix

Known as

64 Profession

65 Practice name

66 Referrer's Address — House Name/Site

Number Street

Line 1

Line 2

Line 3

Town

County

Postcode

67 Telephone

68 E-mail

Q Consent

Warning: If consent to this referral has not been provided, the referral will NOT be accepted. An individual under the age of 16 can consent for their own treatment if they have been determined to be Gillick competent. If a best interest decision has been made for someone who lacks capacity to consent for their own treatment you must provide documentation of this decision along with this referral.

69 Please select the statement which best describes the method of consent.

The client **has** capacity/competence

- ◯ The client has capacity/competence and **consents** to this referral
- ◯ The client has capacity/competence and **does not consent** to this referral

The client **does not have** capacity/competence

- ◯ Consent was given by parent as client is under 16 and not competent
- ◯ Consent was given by Lasting Power of Attorney (go to **70**)
- ◯ Consent was given by court appointed deputy (go to **70**)
- ◯ Consent was given by best interests decision, **documentation must be provided**

70 Name of Lasting Power of Attorney or court appointed deputy

R Declaration

By signing this form I confirm that I am the referrer, as listed above, and the information I have provided is correct to the best of my knowledge, and I confirm that my client is aware of and consents to the information I have provided.

71 Your name in BLOCK CAPITALS

72 Signing date

Before you return this form, please check that you have completed all the mandatory sections marked in **GREEN**.

Incomplete forms will be returned without processing.

For help in completing this form and other information
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Reset Form