# Wheelchair and Seating Prescription Request Form

Specialist Wheelchair Services

1. This form can only be completed by an Occupational Therapist or Physiotherapist
2. All sections of this form must be completed for the prescription to proceed
3. Equipment will only be provided for individuals who meet the eligibility criteria for provision
4. Please provide this Prescription Request at least 2 weeks before the wheelchair and seating is required
5. Final provision is at the discretion of the Specialist Wheelchair Services
6. EQUIPMENT WILL NOT BE ISSUED PRIOR TO RECEIPT OF THE 'CONDITIONS OF LOAN' FORM
7. THE PRESCRIBING THERAPIST IS REQUIRED TO HAND OVER ANY EQUIPMENT PRESCRIBED

| **Personal Details** | |
|---|---|
| Title: Mr / Mrs / Ms / Miss / Mstr / Other | NHS No: |
| Surname: | First Name: |
| Date of Birth | Gender: |
| Home Address: | |
| | Post Code: |
| Home telephone: | Mobile: |
| Preferred method of contact: | Email address: |
| GP Name: | Practice: |
| Address: | |
| Post Code: | Telephone No: |

| **Next of Kin** | Nominated Contact Person: |
|---|---|
| Relationship: | Relationship: |
| Telephone no: | Telephone no: |

**Power of Attorney**

☐ N/A ☐ EPA ☐ LPA (Finance/ Property) ☐ LPA (Health/Welfare)

Details: .....

**Children**

Primary Carer .....

Person with Parental Responsibility .....

Is this child subject to safeguarding plan? YES ☐ NO ☐

| **Other Health Professionals Involved (e.g. PT,OT, SW, SALT, Dietician, DN, Consultant)** | | |
|---|---|---|
| Name: | Agency: | Tel. No.: |
| | | |
| | | |
| | | |

## Patient's Equal Access Form

**Why we need you to complete this form:**

We have a legal duty to ensure that patients accessing our services are treated fairly. Please complete this form to help us comply with our duty.

## Ethnicity

Please indicate your ethnic background by ticking one box below ☑. This would assist to identify earlier treatment for certain illness such as diabetes or high blood pressure, which may affect some patients more than others.

**White**

☐ British (Eng / Scot / Welsh)
☐ Irish
☐ Other White Background

**Please specify ……**

**Mixed**

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Other Mixed Background

**Please specify ……**

**Black or Black British**

☐ Caribbean
☐ African
☐ Other Black Background.

**Please specify ……**

**Asian or Asian British**

☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Other Asian Background

**Please specify……...**

**Other Ethnic Groups**

☐ Chinese
☐ Any other ethnic group

**Please specify ……..**

☐ **Declined to disclose (refused)**

Do you speak English? ☐ Yes ☐ No

Do you need a qualified interpreter? ☐ Yes ☐ No

If yes, please indicate which language: .....

What is your preferred language? .....

## Healthy Living

Please answer these questions to offer you services which support healthy lifestyles

1) What is your smoking status (tick one box only ☑)

Never smoked ☐ Thanks, you do not need to answer question 2

Ex-Smoker ☐ Thanks, you do not need to answer question 2

Current smoker ☐ Please **answer** question 2

2) If you currently smoke, would you like to be offered a referral to our Stop Smoking team? ☐ Yes ☐ No

**Reason for Referral** (please state):

**Medical Condition/s** ☐ Improving ☐ Stable ☐ Deteriorating ☐ Rapidly Deteriorating

Diagnosis and Past Medical History:

Is the wheelchair essential for discharge? ☐ N/A ☐ No ☐ Yes Discharge Date:

**Note - Wheelchairs are only considered essential for discharge by the Specialist Wheelchair Services where provision will enable the person to be independent of carers**

**Medical Background**

Medication (including doses): .....

.....

.....

Allergies: ☐ No ☐ Yes details: .....

Cognition: .....

Vision: .....

Seizures: .....

Supplementary oxygen required? ☐ No ☐ Yes details: .....

Surgery (past/planned): .....

History of falls: .....

History of pain: .....

Pressure area (grade/location): .....

Any other alerts (behaviour, substance use, MRSA, etc) ? .....

.....

Is the individual medically unfit to travel in transport? ☐ No ☐ Yes details: .....

Contraindications for self propelling (i.e. respiratory, heart or arthritic conditions, cognitive issues)?

.....

**Note - If requesting a self propelling wheelchair with existing contraindications, please request an additional 'Medical Advice Form for Self Propelling' to complete in addition to this form**

**Mobility and Transfers** (state aides used, assistance required and distance)

Mobility indoors: .....

Mobility outdoors: .....

Sitting balance: ☐ Independent ☐ Short periods ☐ With assistance ☐ Dependent

Transfers: ☐ Independent ☐ Assistance of 1 ☐ Assistance of 2

Transfer aides ☐ Nil ☐ Slide board ☐ Rota stand ☐ Hoist ☐ Other: .....

## Social Support and Care

| | |
|---|---|
| Family/ Friend ☐ | Formal/ Paid ☐ |
| Times per day: | Carers for: |
| Does the carer have any difficulties: | |
| Folding a wheelchair: ☐ YES ☐ NO | Lifting a wheelchair in/out of a car: ☐ YES ☐ NO |
| Pushing a wheelchair: ☐ YES ☐ NO | Fitting accessories to wheelchair: ☐ YES ☐ NO |
| Other: | |

## Accommodation

☐ House ☐ Maisonette ☐ Bungalow

☐ Residential/NH ☐ Flat Floor…… Lift Access ☐ Yes ☐ No

Tenure of property ☐ Owner ☐ Council/Housing ☐ Private rental

Access

Sufficient circulation space indoors ☐ Yes ☐ No

Sufficient door way width ☐ Yes ☐ No

Steps ☐ No ☐ Yes Details/ How Many .....

Other:

Is appropriate static seating/ lounge chair in place? ☐ Yes ☐ No

If not has a referral been made for this? ☐ Yes ☐ No

To whom?

## Waterlow Pressure Ulcer Prevention/ Treatment Policy

**Note - Ring scores in table then add and score total. More than one score per category can be used**

| **Build/ Weight for Height** | | **Skin Type Visual Risk Areas** | | **Sex Age** | | **Malnutrition Screening Tool (MST)** (Nutrition Vol.15, No.6 1999 – Australia) | |
|---|---|---|---|---|---|---|---|
| Average | | | | | | **A** - Has patient lost weight recently? | **B** – Weight loss score |
| BMI = 20-24.9 | 0 | Healthy | 0 | Male | 1 | Yes - Go to B | 0.5 – 5kg = 1 |
| Above average | | Tissue paper | 1 | | | No -Go to C | 5 - 10kg = 2 |
| BMI = 25-29.9 | 1 | Dry | 1 | Female | 2 | Unsure - Go to C and score 2 | 10 - 15kg = 3 |
| Obese | | Oedematous | 1 | | | | > 15kg = 4 |
| BMI > 30 | 2 | Clammy (temp) | 1 | 14 – 49 | 1 | | Unsure = 2 |
| Below average | | Discoloured | 2 | 50 – 64 | 2 | | |
| BMI < 20 | 3 | (grade 1) | | 65 – 74 | 3 | **C** – Patient eating poorly or lack of appetite | **Nutrition Score** |
| | | Broken spots | 3 | 75 – 80 | 4 | 'No' = 0, 'Yes' Score = 1 | If > 2 refer for nutrition |
| BMI = Wt(kg)/Ht (m) | | (grade 2-4) | | 81+ | 5 | | assessment/ intervention |

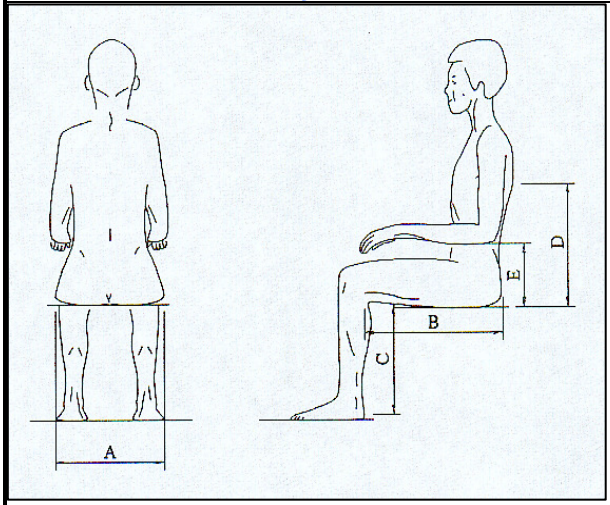
| **Continence** | | **Mobility** | | **Special Risks** | | | |
|---|---|---|---|---|---|---|---|
| | | | | **Tissue Malnutrition** | | **Neurological Deficit** | |
| Complete / catheterised | 0 | Fully | 0 | Terminal cachexia | 8 | Diabetes , MS, CV A | 4 |
| | | Restless/ fidgety | 1 | Multiple organ failure | 8 | Motor / sensory | 5 |
| Urine incontinence | 1 | Apathetic | 2 | Single organ failure | 5 | Paraplegia (Max of 6) | 6 |
| | | Restricted | 3 | (resp, renal, cardiac) | | **Major Surgery or Trauma** | |
| Faecal incontinence | 2 | Inert/ traction | 4 | Peripheral vascular disease | 5 | | |
| | | Chair bound | 5 | Anaemia (Hb < 8) | 2 | Orthopaedic/ Spinal | 5 |
| Double incontinent | 3 | e.g. wheelchair | | Smoking | 1 | On table > 2 hrs # | 5 |
| | | | | | | On table > 6 hrs # | 8 |

| **SCORE** | | **SCORE TOTAL** | | **Medication – Cytotoxics, long term/ high dose steroids. Anti-inflammatory, Max of 4** |
|---|---|---|---|---|
| 10+ At risk | | | | |
| 15+ High risk | | | | **#** Scores can be discounted after 48 hours provided patient is recovering normally |
| 20+ Very high risk | | _____ | | www.judy-waterlow.co.uk |

History of pressure sores (past and present), pressure management equipment/ techniques: .....

.....

| **Posture** | **Note - NAD = no abnormality detected** | | | | |
|---|---|---|---|---|---|
| Pelvis: | ☐ Neutral | ☐ Oblique | ☐ Rotated | ☐ Anterior Tilt | ☐ Posterior Tilt |
| Spine: | ☐ NAD | ☐ Kyphosis | ☐ Scoliosis | ☐ Lordosis | ☐ Leaning |
| Trunk: | ☐ NAD | ☐ High Tone | ☐ Low Tone | ☐ Variable | ☐ Fixed Deformities |
| U/Limbs: | ☐ NAD | ☐ High Tone | ☐ Low Tone | ☐ Variable | ☐ Fixed Deformities |
| L/Limbs: | ☐ NAD | ☐ High Tone | ☐ Low Tone | ☐ Variable | ☐ Fixed Deformities |
| Does this person have complex seating needs? | | | | ☐ Yes | ☐ No |
| Other comments/ observations: | | | | | |

| **Measurements (Body Dimensions)** | **Note – measure in sitting using a straight or rigid tape measure** |
|---|---|
|  | Height |
| | Weight (*essential) |
| | A – Hip Width |
| | B – Upper leg length (L) (R) |
| | C – Lower leg length (L) (R) |
| | D – Height of scapular (inferior angle) |
| | E – Elbow height (L) (R) |
| | Other: |

| **Wheelchair Requirements** | | ☐ Less than 6 months | ☐ More than 6 months |
|---|---|---|---|
| Frequency of use: | ☐ Less than 1 day/ week | ☐ 2-3 days/ week | ☐ Daily |
| Length of time sitting: | ☐ Less than 3 hours | ☐ More than 3 hours | |
| Where will chair be used: | ☐ Indoors | ☐ Outdoors | ☐ Both |

| **Equipment on Issue or Trialled** ☐ Nil | ☐ Issued | ☐ Trialled |
|---|---|---|
| Supplied by: | | |
| Wheelchair: | Serial No: | |
| Tag No: | Seat width x depth | |
| Date of issue: | Seat to floor height: | |
| Accessories: | | |
| Any issues/problems with the current wheelchair: | | |
| Details and outcome of any wheelchair equipment trialled: | | |

## Goals for Wheelchair and Seating Provision

**Note – Ensure all goals are specific, measureable, achievable, realistic and timed (SMART)**

**Client Goals:**

**Assessor Goals:**

## Problem Solving Summary

**Note - All identified risks must be documented and managed (e.g. stability, pressure, posture, access, medical etc)**

| Issues/ risks discussed | Possible solutions |
|---|---|
| Safeguarding issues? ☐ No ☐ Yes (Discuss) | |

## Additional Information

## Equipment Requested

**Note – Provision of more complex equipment will require assessment by the Specialist Wheelchair Services**

| | | | | |
|---|---|---|---|---|
| **Manual Wheelchair (Mandatory)** | ☐ Self propel (S/P) | | ☐ Attendant propel (A/P) | |
| | ☐ 15”x16” | ☐ 16”x16” | ☐ 17”x17” | ☐ 18”x17” |
| **Cushion** | ☐ Flat standard foam – low risk | | | |
| | ☐ Flat memory foam – medium risk (e.g. Community One) | | ☐ Contoured – medium risk (e.g. Lowzone) | |
| | ☐ Flat memory foam – high risk (e.g. Sunmate or Super Contour) | | ☐ Contoured – high/ very high risk (e.g. Flotech Solution) | |
| | **Note – Pressure risks needs to account for frequency and duration of use in addition to identified clinical risks** | | | |
| **Backrest** | ☐ Qbitus back with lateral supports | | ☐ Qbitus crescent infill back (1½”) | |
| | ☐ Jay Lumbar Support | | | |
| **Accessories and Modifications** | ☐ Anti tippers | | ☐ Rear wheels set back | |
| | ☐ Stump board - ☐ Left ☐ Right | | ☐ Qbitus Unifit armrests | |
| | ☐ Bexhill armrest - ☐ Left ☐ Right | | ☐ Angle adjustable footplates | |
| | ☐ Extended brake levers - ☐ Left ☐ Right | | ☐ Oxygen carrier | |
| | Footboard (only available with standard foot plates) Depth: ☐ 8” | | ☐ 10” | ☐ 12” |
| | **Note- Prescription request of an O2 cylinder holder is only permitted for palliative cases, where an ‘O2 Medical Advice Form’ (please request) has been completed/ returned by the O2 prescriber. A Specialist Wheelchair Service RE may also be required to accompany handover** | | | |

**Delivery address and instructions:** .....
.....
.....

## Prescribing Therapist’s Details (please tick to indicate acceptance of the following statements):

☐ The service user is aware this referral is being made

☐ I have completed this assessment form truthfully and accurately

☐ I have attached a signed Terms and Conditions of Loan form and provided a copy to the Service User

☐ I agree to complete the handover of the wheelchair and seating

☐ Following handover I agree to forward the completed Handover Certificate to the Wheelchair Services

☐ I acknowledge that final prescription is at the discretion of the Specialist Wheelchair Services

**Signed:** ..... **Assessor Name:** .....

**Designation:** ..... **Date:** .....

**Work Location:** ..... **Phone:** .....

**Email:** ..... **Fax:** .....

**Please Return this Form to:**

**Central London Specialist Wheelchair Services**
(Covering: Westminster, Kensington and Chelsea and Hammersmith and Fulham)

Direct Duty contact: (for therapists only):
Tel: 0208 962 3932 (Daily 9am to 12pm)
Email: Duty.Therapist@clch.nhs.uk

306 Kensal Road
London
W10 5BE

Tel: 0208 962 3939
Fax: 020 8962 3965
Email: clcht.wheelchairs@nhs.net

**Central London Specialist Wheelchair Services (Barnet)**
(Covering: Barnet)

Direct Duty contact: (for therapists only):
Tel: 0845 389 2889 (Monday/Wednesday/Friday 9am – 12.30)
Email: Barnet.Duty.Therapist@clch.nhs.uk

Edgware Community Hospital
Ground Floor Deansbrook House
Burnt Oak Broadway
Edgware
HA8 0AD

Tel: 0845 389 2889
Fax: 0208 349 7435
Email: CLCHT.barnetwheelchairservice@nhs.net

**Approved Repairers – Nottingham Rehabilitation Supplies (NRS)**

Once the order has been raised by the Specialist Wheelchair Service, NRS will be instructed to contact the external therapist to arrange delivery of the equipment. If you have any queries relating to delivery of equipment please contact NRS directly.

Tel: 0845 045 0194

# Terms & Conditions of Loan

**Service User:** _____ **Ref No:** _____

## Section 1 – User Responsibility

All equipment provided by the Wheelchair Service remains the property of the National Health Service (NHS) and is loaned to you under the following conditions.

- Your details are automatically shared with our database providers, Soft Options and Approved Repairers, Nottingham Rehabilitation Supplies (NRS).
- It is for your use only and must not be used by anyone else or for any other purpose other than that for which it was provided.
- It is your responsibility to use the equipment safely as instructed by the Wheelchair Service and the manufacturer's user manual.
- The equipment must be kept clean and maintained in good order. Any faults or problems should be reported to the Maintenance & Repair Contractor – NRS.
- If you have a powered chair, you must look after the battery as shown in the instructions given with the chair. Good ventilation is needed when charging the battery to avoid a build up of harmful gases.
- No alterations or attachments may be made to the equipment without prior agreement from the Wheelchair Service. This includes the fitting of third party equipment such as power packs which may invalidate the manufacturer's warranty. In situations where this is done without prior consent from the Wheelchair Service, the wheelchair may be removed permanently and any subsequent repair costs passed on to the Service User.
- It is advisable that you inform your home insurers to amend your policy to include the wheelchair and accessories or alternatively take out insurance to cover your wheelchair and accessories.
- If the equipment is no longer required, for any reason, you must inform the Wheelchair Service. Arrangements will then be made for it to be collected. It **must not** be disposed of in any other way or given to anyone other than the Wheelchair Service or Repair Contractor.
- You **must inform** the Wheelchair Service immediately if any or the equipment is:
    - Lost or stolen
    - Involved in an accident
    - Damaged.

- You must also inform the Wheelchair Service if you change your address. If you move out of area your equipment may be taken with you. Please inform us of your forwarding address so that we can transfer your notes to your new Wheelchair Service.
- You must also inform the Wheelchair Service if you move into a Nursing or Residential Home.
- You must also inform the Wheelchair Service if you intend to leave the country for any period of time exceeding 90 days.
- If you take the equipment oversees on holiday you are advised to take out insurance as the user is responsible for the cost of any loss or damage incurred abroad.

## Section 2 – Adverse Incidents

Wheelchairs and associated equipment are defined as Medical Devices. An adverse incident is an event which causes, or has the potential to cause, unexpected or unwanted effects involving the safety of users or other persons. It is important to identify what may constitute an adverse Incident. All Adverse Incidents must be reported to the Medicines & Healthcare Products Regulatory Agency (MHRA)

If you feel that an accident / incident has occurred which constitutes an adverse Incident, you must contact the Wheelchair Service immediately and they will give advice on appropriate action to take.

## Section 3 – Repairs

**For repairs to Manual & Electrically Powered Indoor Chairs (EPIC) and Electrically Powered Indoor & Outdoor Chairs (EPIOC)**

Nottingham Rehabilitation Supplies (NRS)
4 McNicol Drive
Park Royal
London, NW10 7AW
Tel: 0845 045 0194
Fax: 0208 965 9672

**Hours of Work:**
8.00 am to 5.00 pm Monday to Friday
**Repair Service available:**
8.00 am – 5.00 pm. Monday to Friday
There is an out of hour's service operating in the evenings and weekends.

- The Wheelchair Service is only responsible for repairs relating to normal wear and tear of your equipment.
- The equipment **must not** be repaired by anyone other than the Repair Contractor – NRS.
- All work carried out by the Repair Contractor will be paid for by the Wheelchair Service. **However,** the Wheelchair Service is not responsible for costs of repairs through misuse or negligence.

- The Repair Contractor will come to your home or other appropriate venue (Day Centre, School, etc,) to carry out repairs.
- If your wheelchair has to be removed by the Repair Contractor for completion of repairs at their factory, we may be able to provide you with a temporary replacement wheelchair. This wheelchair will only be a standard model and will not necessarily be the same model or size as your own issued wheelchair.

**Maintenance Service available:**

- If you have an Electric Powered Indoor or Indoor Outdoor Wheelchair (EPIC or EPIOC), the Repair Contractor (NRS) is responsible for carrying out an annual service on it. You will be contacted by them to arrange a time for this service to take place.
- At the present time there is a facility for Servicing of manual wheelchairs. You will be informed accordingly by the Wheelchair Service at the time of provision, if planned preventative maintenance (PPM) is recommended for the particular items issued to you.

**SPECIFIC INSTRUCTIONS FOR USE**

……

……

……..

…….

…….

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*I agree to accept the wheelchair prescribed for me by the Wheelchair Service, under the Conditions of Loan described above.*

| |
|---|
| Signed: |
| Name (Please print): |
| Signature of Therapist |
| Name (Please print): |
| Date: |

# Handover Certificate
# For Non Powered Wheelchairs

Specialist Wheelchair Services

| SERVICE USER NAME: | MANUFACTURERS NO. | WHEELCHAIR SERVICE SERIAL NO: |
|---|---|---|
| SERVICE USER NO: | | |
| CHAIR MODEL: | CHAIR SIZE: | COLOUR: |
| OTHER SEATING/ACCESSORIES: | | |

The Clinician is to demonstrate to the Service User and Representative as appropriate the following (please indicate in the box with a tick when the task has been completed):

- ☐ How to open and fold the wheelchair(s)
- ☐ How to fold the back rest
- ☐ Demonstrate the footrest mechanism, and adjust to suit
- ☐ How to release and replace the armrests
- ☐ How to enter and leave the wheelchair
- ☐ How to operate the brakes
- ☐ Demonstrate removal and refit of Quick Release Wheel, if fitted
- ☐ Adjust lap strap and demonstrate operation
- ☐ Demonstrate how to manoeuvre the wheelchair up and down kerbs
- ☐ Adjust to suit and demonstrate any other equipment
- ☐ Handover manufacturer's user handbook to Client or representative

**Signature (Service User/Representative):** _____

**Print NAME of Service User Representative/Relationship:** _____

**Name of Clinician:** _____

**Signature of Clinician:** _____

**Date:** _____