Guidance Notes for the Completion of the WestMARC Electric Powered Wheelchair Referral Form

This document has been designed to assist you in completing the WestMARC electric powered Wheelchair Referral Form. The aim of this document is to help referrers to give WestMARC the most accurate and relevant information about their client.

The information you provide in the form will be used to determine the most appropriate pathway for your client. The form must be completed in full. Failure to do so will result in your referral being delayed, or rejected. **Please write information in full and do not use abbreviations.**

The form is used to triage referrals to allow access to clinical assessment for a first power chair, this is not a request for equipment provision. **Completion of this form does not guarantee provision.**

If patient requires a manual wheelchair, please refer to manual chair referral form and related guidance notes.

This form is intended for new patients (please see Reporting Form for existing patients).

New clients must be referred by a healthcare professional or social worker registered with one of the following bodies;

- Nursing and Midwifery Council,
- Health and Care Professions Council,
- General Medical Council
- Scottish Social Work Council.

NHS Scotland wheelchair eligibility criteria is available here:

Rehabilitation Technology Information Service (ReTIS) (scot.nhs.uk)

If a client meets the NHS Scotland wheelchair eligibility criteria they will be offered a clinical assessment

Specific guidance: Please note hospital discharge is not a suitable reason to prioritise, as a manual wheelchair should be available.

Section 1: Client Details & Section 2: Alternative Contact Details

Please provide all requested demographic details and include up-to-date telephone number(s).

Section 1: Client Details

Title:	Ms	CHI number:	1234567890
Forename(s):	Anna	Surname:	Smith
Date of birth:	12/03/1945	Gender:	Female
Tel (home):	01234 567 8910	Tel (mobile):	0123456789
Email:	patient@mail.com		
Height:	5'5" ○ cm ◉ feet/inches	Weight:	12st ○ kg ◉ stone/lbs

Home address & postcode:	123 Patient Address Glasgow G12 345
Delivery address & postcode:	123 Patient Delivery Address Glasgow G67 891
Communication requirements: e.g. Interpreter, communication via carer, prefers email contact.	Anna is able to communicate freely however prefers to have contact via email. No communication issues to note.

Section 2: Alternative Contact Details (e.g. care worker, family member*)

☐ **Not applicable –** contact client directly using details above

Name:	David Smith	Relationship to client:	Husband
Telephone:	As above	Email:	

* Please refer to Section 9 to confirm client consent

Section 3: GP Details

Please include all of client's current GP information

Section 3: GP Details			
GP Practice Name:	GP Practice	GP Practice Number:	12345
Telephone:	01234 5678910		
Surgery/practice address and postcode:	GP Practice Practice Address Glasgow G12 345		

Section 4: Priority

As stated on the form we reserve the right to reassess urgency.

Urgency is assigned to clients with a rapidly degenerative and changing condition such as Motor Neurone Disease (MND) and clients with a palliative condition.

Please note hospital discharge is not a suitable reason to prioritise, as a manual wheelchair should be available.

Section 4: Priority		
Is this an urgent referral? We reserve the right to reassess urgency.	☒	No
	☐	Yes: the client has a rapidly degenerative or palliative condition
If 'yes' please indicate prognosis:		

Section 5: Clinical Information

Diagnosis: Please include as much information as possible about all clients known conditions, including primary condition and previous medical history. Please describe how your client is affected by their diagnosis. Please do not use abbreviations.

Seizures and blackouts: Include information of any seizures/blackouts within the last year. Include information regarding any medication the patient is taking to manage seizure activity. Patients must meet DVLA standards in relation to seizure activity.

Visual Impairment: Include up to date information regarding any significant visual impairment eg: cataracts, glaucoma, optic neuritis, hemianopia and double vision. Last optician appointment date and outcome of this. Please note, if a client does not meet DVLA standards for vision they will not be permitted to operate a powered wheelchair outdoors.

History of Pressure Ulcers: Please provide as much information as possible regarding pressure issues either historical or current. If 'yes' is selected on the form please state the grade, location and size of the pressure sore(s). Include details of current pressure care management plan.

Please state if the client is capable of sitting in a standard chair unsupported. If 'no' is selected please describe the presenting issues: The reason we ask how a client can sit in a chair is to determine whether further support is required in the wheelchair i.e. postural supports, headrest etc. Please provide us with as much information as possible regarding clients posture when seated. Examples include leaning to one side and sliding down in the chair.

Please note that if a client is bed bound we are unable to assess for wheelchair provision until suitable static seating is in place, a graded seating programme has been implemented and your client is getting up to sit safely on a daily basis.

Section 5: Clinical Information	
Diagnosis: Please include all known conditions. Please do not use abbreviations.	Primary Progressive Multiple Sclerosis Coronary Obstructive Pulmonary Disease Hypertension
Does the client experience seizures or blackouts? **If 'yes' when was their last seizure? Please give further details**	☒ Yes ☐ No Patient has had 1 episode of blackout in the last year. This was investigated and no further follow up was required. Patient does not take any medication for seizures. This happened in January 2024.
Does the client have any visual impairment? (e.g. cataract, hemianopia, double vision, optic neuritis) **If 'yes' please give further details**	☒ Yes ☐ No Patient has cataract in her right eye and is on the waiting list for removal. There is no date for this yet. She wears reading glasses. Last appointment at opticians was 2 months ago approximately.

Does the client have a history of pressure ulcers?	☐ No ☒ Yes, with current pressure ulcers ☐ Yes, historical only
If 'yes' for historic or current ulcers, please state location and grade:	Grade 2 pressure sore on sacrum District nurses visit twice weekly to change dressings Tissue viability have reviewed and advised maximum sitting time out of bed is 4 hours
Detail current pressure care management plan:	Maximum sitting out time is 4 hours as per tissue viability. Advised to transfer back into bed to ease pressure. Carers check daily to ensure dressing is intact and to report back any issues.
Is the client capable of sitting in a standard chair unsupported?	☒ No ☐ Yes
If 'no', please describe issues (e.g. skeletal deformity)	Leans over to the right hand side with head flexed forwards. Uses a tilt in space static chair which has been provided by community occupational therapy.

Does the client have a history of pressure ulcers?	☐ No ☒ Yes, with current pressure ulcers ☐ Yes, historical only
If 'yes' for historic or current ulcers, please state location and grade:	Grade 2 pressure sore on sacrum District nurses visit twice weekly to change dressings Tissue viability have reviewed and advised maximum sitting time out of bed is 4 hours
Detail current pressure care management plan:	Maximum sitting out time is 4 hours as per tissue viability. Advised to transfer back into bed to ease pressure. Carers check daily to ensure dressing is intact and to report back any issues.
Is the client capable of sitting in a standard chair unsupported?	☒ No ☐ Yes
If 'no', please describe issues (e.g. skeletal deformity)	Leans over to the right side with head flexed forwards. Used a tilt in space static chair which has been provided by community occupational therapy.

Section 6: Current Mobility/Equipment Used

Please complete all sections in regards to how the patient mobilises in their home.

Section 6: Current Mobility/Equipment Used			
Does the client currently mobilise around their own home?	☐ Yes ☐ No		
If 'yes', how do they manage this?			
Walks independently (no assisstance)	☐ Yes	☐ No	☐ With difficulty
Walks with equipment (e.g. walking stick or wheeled frame)	☐ Yes	☐ No	☐ With difficulty
Assisted by another person	☐ Yes	☐ No	☐ With difficulty
Currently walking, but unsteady	☐ Yes	☐ No	☐ With difficulty
Self-propels a manual wheelchair	☐ Yes	☐ No	☐ With difficulty
Type of wheelchair/mobility device currently used:			
No device currently used	☐		
Manual self-propelled wheelchair (pushed by the occupant and/or someone else; large rear wheels)	☐		
Manual attendant propelled wheelchair (pushed by someone else; small rear wheels)	☐		
Electrically powered wheelchair	☐		
Where is the current device used?	Indoors only ☐	Indoor/outdoor ☐	Outdoor only ☐

Section 7: Home environment & Support Network

Type of accommodation: Please specify the type of housing the client resides in. This should be the clients permanent address.

Access to clients' property: Please specify the type of access to the property. Please note that provision for indoor/outdoor use will not be permitted whilst temporary ramps are in use due to significant safety issues.

Within the clients property: Please provide detailed information regarding the inside layout of the property. This should include the layout, any tight turns into any of the rooms, turning angles, is there sufficient space within the rooms to turn a wheelchair? Please include door widths where possible. Include information about any raised thresholds in the doorways.

Carer arrangements and frequency: Please include frequency of care visits and who provides these visits. What support do the carers provide? What company provide the care – include contact details.

Does the carer live at the same address: If 'yes' please include any supporting information about the carers health and wellbeing as appropriate.

Section 7: Home Environment & Support Network

Type of accommodation:

House	☐	
Flat	☒	If flat, which floor: second floor
Other	☐	If other, please describe:

Access to client's property:

Level access	☐	
Steps	☐	
		Number of Steps: Front entrance: 2 Rear entrance: 2
Ramp access	☐	
		If 'yes', what type of ramp: Permanent ☐ Temporary ☐
Lift access	☒	
		Is there sufficient space within the lift for the wheelchair? Yes ☒ No ☐

Within client's property:

Is there sufficient space within the property for wheelchair use? Yes ☒ No ☐
(Consider narrow hallways, narrow doorways, sharp turning angles)

Please provide details including door widths:

Front door leading to narrow hallway (29" width), tight turn into the living room on the right hand side. At the end of the hallway is the bedroom. Left turn from hallway into the kitchen. Wet floor shower room in situ. Turning space within the living room however lack of space within the bedroom due to equipment. All door widths are 32".

Detail any carer arrangements including frequency:

Package of care 4x daily provided by council home care service. Carers provided support for all activities of daily living including washing, dressing, transfers, medication and meal preparation. Care company can be contacted on 12345 678 9101.

Does the carer live at the same address? Yes ☒ No ☐

Please provide details of any factors to consider about the carer
(e.g. their health and wellbeing)

Husband also provides a degree of care. He still works full time.

Section 8: Any further infrmation

Please include any other relevant information.

Please indicate if any additional wheelchair accessories or adaptations should be considered. E.g. fitting of swing-away armrests.

Please indicate any other issues we should be aware of e.g. Adult Support and Protection

Section 8: Further Supporting Information
Patient is currently being assessed for moving and handling equipment (hoist). Currently using stand aid to transfer however this has been deemed unsafe. Patient has allocated social worker (name) who can be contacted on 01234 546 7890. Patient lives with her husband who continues to work full time however the patient is able to attend any appointments via patient transport. Patient would like to be considered for a powered wheelchair as she does not have any other means of mobilising in her home. It is hoped that if the patient meets the eligibility criteria a power chair will increase her quality of life and ability to participate in activities of daily living, reduce the need for full time care package and help improve patient's mental health.

Section 9: Client Capacity and Consent

Please state if your client has the capacity to consent to the referral being made and any subsequent intervention.

If your client does not have capacity to consent please tell us who has legal rights, such as guardianship or power of attorney, to consent on the client's behalf. This could be a spouse, family member or Social Worker.

Section 9: Client Capacity and Consent	
Does your client have capacity to consent to intervention?	☒ Yes ☐ No
If your client does not have capacity to consent, please confirm who has legal rights to consent on the client's behalf.	
Does your client consent to this referral?	☒ Yes ☐ No
If no, state why the referral is in your client's best interests.	
Does your client consent to us sharing information with you?	☒ Yes ☐ No

Section 10: Referrer Details

This form must be completed by a Healthcare Professional or Social Worker registered with one of the following bodies:

· Health and Care Professions Council

· General Medical Council

· Nursing and Midwifery Council

· Scottish Social Work Council

The Powered Wheelchair Referral Form must be completed in full or the referral will be rejected.

Section 10: 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:	Jane Smith	Position:	OT
Telephone ☎ :	0141 123 4567	Mobile:	0712345678
Professional registration number:	OT12345		
Email ✉ :	jane.smith.OT@nhs.scot		

Work address and postcode:	Queen Elizabeth University Hospital, 1345 Govan Road, Glasgow G51 4TF
Please indicate the best method of contact and your working hours should we require to contact you for further clarification:	
I work part time Monday, Tuesday and Thursday 8am-4pm Please contact me by email as I am often out of the office on home visits.	

Please save this form in PDF format and email a copy to: ✉ westmarc@ggc.scot.nhs.uk