**Wheelchair/Buggy and Seating Referral Form**

Please ensure that all relevant sections of this form are completed accurately using BLOCK CAPITALS. Incomplete and unsigned forms may not be accepted and could delay provision. An online tutorial video on how to complete this form is available at [www.smart.scot.nhs.uk](http://www.smart.scot.nhs.uk)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient *(tab along in grey boxes to complete)* | | | | | | | | | | |
| Surname: | | | Home address: | | | | | | | |
| Forename(s): | | |  | | | | | | | |
| DOB/CHI Number: | | | Postcode: | | | | | | | |
| Sex: | | | Tel. no: | | | | | | | Other tel. no: |
| Delivery address and contact (if different): | | | | | | | | | | |
| General Practitioner | | | | | |  | School/Day Centre (if applicable) | | | |
| Name: | | | | | |  | Name**:** | | | |
| Address: | | | | | |  | Address: | | | |
| Postcode: | | | | | |  | Postcode: | | | |
| Tel: | GP Practice code: | | | |  | | | Tel: | | |
| Referrer (Must be registered with HCPC, <NMC> or GMC<>) | | | | | | | | | | |
| Name: | | | | Address: | | | | | | |
| Profession: | | | |  | | | | | | |
| Signature: | | | | Postcode: | | | | | | |
| Date: | | | | Tel: | | | | | | |
| Clinical information | | | | | | | | | | |
| Primary diagnosis: | | | | | | | | | | |
| Any other relevant clinical information: | | | | | | | | | | |
| **Can standard wheelchair/buggy be issued without assessment?** YesNo *(complete as applicable)*  If **yes** please only complete this page. If **no** please go to page 2 and complete the rest of the form. | | | | | | | | | | |
| Provision of standard wheelchair/buggy | | | | | | | | | | |
| Hip width (cm): | | Weight (kg): | | | | | | | Height (m): | |
| **Type of wheelchair/buggy required:**  Self propelled manual chair  Attendant propelled manual chair Major buggy | | | | | | | | | | |
| **Additional requirements** (e.g. cushion, lap strap): | | | | | | | | | | |
| **For children only, please provide the following information** | | | | | | | | | | |
| Shoulder height (mm): | | Thigh length (mm): | | | | | | | Pelvic width (mm): | |
| Head height (mm): | | Shin Length (mm): | | | | | | |  | |
| Are swing-away footplates necessary for standing transfers? YesNo *(complete as applicable)* | | | | | | | | | | |

Please post to **Referrals, SMART Centre, Astley Ainslie Hospital, 133 Grange Loan, Edinburgh EH9 2HL** or email to [**Smart.Referrals@nhslothian.scot.nhs.uk**](mailto:Smart.Referrals@nhslothian.scot.nhs.uk)If you or the patient have not heard from us within one month, please contact the service. Tel. 0131 537 9177.

# Information required only for patients needing a clinical assessment.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Availability | | | | | | |
| Assessments normally take place at the SMART Centre, Astley Ainslie Hospital, at our nearest satellite clinic or at the patient’s place of residence. Where the assessment takes place will depend on the service required. If the patient is unable to attend a clinic, please give reason and state preference for location: | | | | | | |
| Please indicate by placing a '**Y**' in the box when the patient and/or yourself, or anyone else who should attend an assessment, are available. We will try to avoid inconvenient times, but this may not always be possible. | | | | | | |
|  |  | Monday | Tuesday | Wednesday | Thursday | Friday |
| Patient | am |  |  |  |  |  |
| pm |  |  |  |  |  |
| Referrer or delegate: | am |  |  |  |  |  |
| pm |  |  |  |  |  |
| Other: | am |  |  |  |  |  |
| pm |  |  |  |  |  |
| Is patient available for a cancellation appointment at short notice? YesNo *(complete as applicable)* | | | | | | |
| Does patient have any special requirements (e.g. oxygen, hoisting): | | | | | | |

Clinical Information

|  |
| --- |
| Hearing / visual / communication ability: |
| Details of relevant previous / planned medical or surgical information (including dates): |
| Details of relevant skin care / pressure sore problems (including dates): |
| Description of fixed deformities, limitations in ranges of joint motion and abnormal muscle tone: |
| Wheelchair and seating provision | |
| Current wheelchair / buggy, seating and postural management arrangements: | |
| Description of problem(s) with current provision: | |
| Functional and therapeutic aims of new provision: | |
| Any other relevant information | |
|  | |