WestMARC Powered Wheelchair Referral Form

Main office: WestMARC,
Queen Elizabeth University Hospital Campus,
1345 Govan Road, Glasgow, G51 4TF

☎ 0300 790 0129 ✉ westmarc@ggc.scot.nhs.uk

- This referral should be completed with an understanding of the NHS Scotland wheelchair eligibility criteria (🌐 **https://www.retis.scot.nhs.uk/wheelchaircriteria**) and having read guidance on WestMARC website: 🌐 **https://www.nhsggc.scot/westmarc**
- This is a referral to be clinically assessed for potential powered wheelchair provision, therefore completion of this form does not guarantee provision.
- 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 or Scottish Social Work Council.
- This 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.

Section 1: Client Details

Title:		CHI number:	
Forename(s):		Surname:	
Date of birth:		Gender:	
Tel (home):		Tel (mobile):	
Email:			
Height:	☐ cm ☐ feet/inches	Weight:	☐ kg ☐ stone/lbs

Home address & postcode:

Delivery address & postcode:

Communication requirements:
e.g. Interpreter, communication via carer, prefers email contact.

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

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

Name:

Relationship to client:

Telephone:

Email:

* Please refer to Section 9 to confirm client consent

Section 3: GP Details

GP Practice Name:

GP Practice Number:

Telephone:

Surgery/practice address and postcode:

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 all known conditions.
Please do not use abbreviations.

Does the client experience seizures or blackouts?

☐ Yes ☐ No

If 'yes' when was their last seizure? Please give further details

Does the client have any visual impairment?
(e.g. cataract, hemianopia, double vision, optic neuritis)

☐ Yes ☐ No

If 'yes' please give further details

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:

Detail current pressure care management plan:

Is the client capable of sitting in a standard chair unsupported?

☐ No
☐ Yes

If 'no', please describe issues
(e.g. skeletal deformity)

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:

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

Access to client's property:

Level access	☐	
Steps	☐	
		Number of Steps: Front entrance: Rear entrance:
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:

Detail any carer arrangements including frequency:

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)

Section 8: Further Supporting Information

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 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:		Position:	
Telephone ☎ :		Mobile:	
Professional registration number:			
Email ✉ :			

Work address and postcode:	
Please indicate the best method of contact and your working hours should we require to contact you for further clarification:	

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