**Address: Mobility and Seating Solutions Centre, 3 Edwards Drive, Bounds Green, N11-2HD**

**This form must be FULLY COMPLETED**

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| **SECTION 1: CLIENT’S DETAILS & REASON FOR ASSESSMENT**  |
| **Name of client:**  |  | **Date of Birth:** |  |
| **Permanent Address:** | **Telephone/Mobile Number:** |  |
| **Consent to assess:** |  **Yes  No** | **NHS Number: (if known)** |  |
| **Client’s height: (Essential)** | **Client’s weight: (Essential)** |
| **GP’s Name and Address:** |  |
| **Reason for requesting assessment / Client’s goals:****(*Important to include medical conditions/issues that is affecting your mobility*)** |  |
| **SECTION 2: WHEELCHAIR USE** |
| **How often will the wheelchair be used? Where will the wheelchair be used?**Every day Indoor only5 times a week Outdoor onlyOnce a week or less Both**Function specific use? How long will the wheelchair normally be used per day?**Work More than 3 hoursSchool / College Less than 3 hours Outdoor Leisure/social Occasionally  |
| **SECTION 3: TYPE OF WHEELCHAIR** | **Self-propelling** | **Attendant/Pushchair** |
| **SECTION 4: CARERS DETAILS OR PERSON TO CONTACT (if applicable)** |
| **Name:** |  | **Relationship:** |  | **Tel no:** |  |
| Has use of wheelchair been discussed with your carer: YES / NOAny risks identified that may require follow up visit: YES / NO  |

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| **SECTION 5: ENVIRONMENTAL FACTORS** |
| **Type of accommodation:** Flat Bungalow House Residential/sheltered Nursing Home Flat floor: Is there a lift? Yes No**Who owns the property:** Owner occupied Council/Housing Association Private Rental |
| **Access to home:** | Ramped  Level  Steps |
| **Internal steps/stairs:**  |  Yes No If Yes, how many steps  |
| **Door widths (cm):**  | Front: Kitchen: Toilet: Bedroom 1: Bedroom 2: Hallway width: |
| **Other Comments:** |
| **SECTION 6: OBJECTIVE/POSTURAL ASSESSMENT (Optional - however, this would help speed up the process)** |
| Body Dimensions: |
| Seat Width (A)  |  |
| Seat Depth (B)  |  |
| Seat Height (length lower leg & foot) (C)  |  |
| Armrest height (D)  |  |
| Backrest height (E) |  |
| Height to top of head (F)  |  |
| **Name of person completing the form: (Please Print)** **Telephone no: (If different to above)** **Date form completed:**  | **Send completed self-referral form to the Mobility and Seating Solution Service (MSSS)****Email:****haringey.wheelchair-service@nhs.net****Phone: 020 3074 2850** |