**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 only  5 times a week Outdoor only  Once a week or less Both  **Function specific use? How long will the wheelchair normally be used per day?**  Work More than 3 hours  School / 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 / NO  Any 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**](mailto:haringey.wheelchair-service@nhs.net)  **Phone: 020 3074 2850** |