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

**This form must be FULLY COMPLETED**

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| --- |
| **CLIENT’S DETAILS & REASON FOR REVIEW**  |
| **Name of client:**  |  | **Date of Birth:** |  |
| **Permanent Address:** | **Telephone/Mobile Number:** |  |
| **Consent to assess:** |  **Yes  No** | **NHS Number (if known):** |  |
| **Client’s height: (Not required, if Adult)** | **Client’s current weight: (Essential)** |
| **GP’s Name and Address:** |  |
| **Detailed reason(s) for requesting a review:*****(Please include any new medical information or diagnosis)*** |  |
| **Any hospital admission(s) in the last 6 months:** |  **Yes  No** |
| **If yes, has this affected client’s posture?**  |  **Yes  No** |
| **Any additional or supporting information to help facilitate the review:** |
| **Name of person completing the form: (Please Print)** **Telephone no: (If different to the 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** |