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

**This form must be FULLY COMPLETED**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**](mailto:haringey.wheelchair-service@nhs.net)  **Phone: 020 3074 2850** | | | | |