**Existing Patient Mounting Referral Form**

**Please note:**

* Wheelchair mounting appointments will take place at the Bristol Centre for Enablement or the Plymouth AAC WEST office unless there are exceptional circumstances.
* A maximum of 2 wheelchair mounting systems will be provided (e.g. manual and powered wheelchair, manual and classroom chair) in addition to another mounting system e.g. floor mount or desk mount.

|  |  |
| --- | --- |
| **PATIENT DETAILS** | **REFERRER DETAILS** |
| Name: | Name: |
| DoB: | Relationship to patient: |
| Address: | Telephone: |
| Telephone: | Email: |
| **NEXT OF KIN** | **SCHOOL (if applicable)** |
| Name: | School: |
| Relationship to patient: | Key contact name (e.g. teacher, SENCO): |
| Telephone: | Telephone: |

* Where a child has identical dynamic seats at home and at school, a single mounting system will be provided which can be used in both environments.

|  |  |
| --- | --- |
| **CONSENT** |  |
| Has the patient given consent for the referral? | Yes  No |
| If patient under 16 or unable to consent, who has consented in their best interests: |  |
| Does the patient give consent for AAC WEST to contact their wheelchair service or local OT? | Yes  No |
| *(Required for wheelchair/class chair mounting)* | If patient under 16 or unable to consent, who has consented in their best interests: |
| Does the patient give consent for AAC WEST to contact:  Their place of residence/school/college/care giver/local therapist to arrange an appointment? | Yes  No |
|  | If patient under 16 or unable to consent, who has consented in their best interests: |

|  |  |
| --- | --- |
| **CURRENT AAC SET UP** |  |
| Device: |  |
| Access method: |  |
| Existing mounts – *please list (e.g. floor mount for bed/standing frame, powerchair mount etc)* |  |
| Photo of patient using device in current optimal position | *(Insert here)* |

|  |  |
| --- | --- |
| **REQUESTED MOUNTING** |  |
| Is the referral for… |  |
|  | Bed  Armchair  Standing frame  Wheelchair |
| If referral is for a wheelchair, please specify… |  |
| Make: | Model and size:  Owner:  Planned provision date: |
| Additionally, if referral is for a powerchair what are the patient’s driving permissions? |  |
| Photos of wheelchair  Required photos: side on view of both sides, front on, close up of seat rail on both sides, label with chair specifications. | *(Insert here)* |

|  |  |  |
| --- | --- | --- |
| Signed: | Name: | Date: |