**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.
* 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.

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| **PATIENT DETAILS** | **REFERRER DETAILS** |
| Name:  Pronouns:  He/Him  She/Her  They/Them | Name: |
| DoB: | Relationship to patient: |
| Address: | Telephone: |
| Telephone:  (This number will be used for text message reminders for appointments) | Email: |
| **NEXT OF KIN** | **SCHOOL (if applicable)** |
| Name: | School: |
| Relationship to patient: | Key contact name (e.g. teacher, SENCO): |
| Telephone: | Telephone: |

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| **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?  *(Required for wheelchair/class chair mounting)* | 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 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: |

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| **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)* | |

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| **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, label with chair specifications.  *(Insert here)* | | | | | | |

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| **Signed:** | **Name:** | **Date:** |