Te Whatu Ora
Health New Zealand
Te Toka Tumai Auckland

Referral for Complex Wheelchair Or Seating Assessment

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you enter the correct patient details

MOBILITY SOLUTIONS REFERRAL FOR COMPLEX WHEELCHAIR OR SEATING ASSESSMENT

Please send your referrals to: Email: **mobility@adhb.govt.nz** Ph: 0800 631 1234

- Complete this form as fully as possible to ensure we understand the issues relating to your wheelchair and seating needs.
- If you are self-referring and would like help completing this form, call Mobility Solutions and a therapist will assist you.
- Photographs can be helpful to describe or explain problems.

INCOMPLETE REFERRALS WILL BE RETURNED

Title		Client Name	First:	Last:	
NHI		DOB		Gender: ☐ Male ☐ Female ☐ Another gender ☐ Unspecified	
Address					
Phone	Hm:		Mob:	Other:	
Email					
Preferred method of contact: ☐ Email ☐ Text ☐ Home Phone ☐ Mobile				Dog on Premises? ☐ No ☐ Yes	
Who do you live with? ☐ Alone ☐ Partner ☐ Family ☐ Supported Living ☐ Other				NZ resident? ☐ No ☐ Yes	
Ethnicity?		Interpreter needed? ☐ No ☐ Yes		Language?	
Alternate Contact	Name: Relationship: Phone:			Primary Contact: ☐ Client (as above) ☐ Alternate Contact	

Other therapists/professionals involved – including contact details, e.g. GSE, Rest Home, Community Agencies:

Name	Organisation	Phone

Complete all sections (please print clearly)

Equipment is Essential for:	**Describe current Wheelchair & Seating Equipment** (include make and model if known)
☐ Mobility in the home ☐ Full time education ☐ Full time employment ☐ Vocational training ☐ Main carer of a dependent person	Is equipment MOH Funded? ☐ No ☐ Yes

Meets Level 2 criteria for wheelchair & seating needs – (refer to link below) ☐ No ☐ Yes

https://www.enable.co.nz/service-centre/ems-assessors/get-accreditations/explore-accreditations/wheeled-mobility-postural-management/wheeled-mobility-and-postural-management-level-2/

Relevant indicators:

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REFERRAL FOR COMPLEX WHEELCHAIR OR SEATING ASSESSMENT

CR6718

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Diagnosis & date of onset (if relevant):	**Describe disability, functional limitations, and other health issues:**

Reason for Referral: (please describe in detail to assist with prioritisation)

☐ Person is at risk of injury or loss of independence with key functions (e.g. eating, transferring, mobility). Describe:

☐ Postural integrity and position in sitting is compromised. Describe:

☐ Presence of open pressure injury or where skin breakdown is imminent. Where is it? Date of onset? Describe:

☐ Risk of respiratory, aspiration, digestion/elimination problems. Describe:

☐ Risk to Caregiver (e.g. injury, excessive moving & handling to reposition, difficulty effectively providing care). Describe:

☐ Condition of current equipment. Describe:

Has it been appraised by Accessable for repairs? ☐ No ☐ Yes

☐ Referral related to hospital admission (i.e. planned or unplanned medical event). Describe and/or attach relevant documents:

☐ Transfer of care to Mobility Solutions from another Service Provider:

Other issues e.g. weight change; discomfort; growth; ability to participate in activities (home, education, social, community, work):

Declaration

☐ This is a self-referral. I confirm that the information outlined in this referral is true and accurate. I am aware that this information may be shared with other health professionals.	Date:
	Signed:
☐ This referral was completed truthfully on behalf of the above person. Consent has been given by them or their parent/ guardian for this referral. They are aware that this information may be shared with other health professionals.	Name:
	Relationship:
☐ This referral was completed/updated over the phone/in-person by Mobility Solutions. Information gathered from: ..... Date:.....	Service:
	Ph/Mob:
☐ Photos are attached with clients consent to aid triage.	Email:

If client is over 65 years old and resides in a Rest Home/Hospital, continue to page 3.

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REFERRAL FOR COMPLEX WHEELCHAIR OR SEATING ASSESSMENT

Complete this section ONLY if this person is over 65 years of age and resides in a Rest Home/Hospital

Additional information required for: *(Name)*

The following MOH eligibility information relates to people who reside in residential care

- The wheelchair is needed to support a person's all day functional mobility. It is individualised or customised for their sole use and not suitable for the general mobility needs of other residents within the facility.
- The customised or individualised seating (cushion or backrest) on a wheeled mobility base is necessary because:
  - There is no suitable seating or chair in the facility to meet the person's identified disability related needs and
  - The person has an essential need for, and ability to benefit from, individualised or customised seating, and
  - The impact of the seating not being provided has an effect on the way the person will manage daily living activities, their safety and an impact on carers (including to reduce the need for a higher level of care).

Note:

- Sole use means the equipment has been provided for the person for their individual use only. The equipment is over and above what a residential care provider would be expected to provide and is not for communal use.
- Wheeled mobility is unable to be provided for transport around the facility such as to and from dining room.

In order to prioritise, we require the following additional information before the referral can be considered:

Independent Mobility

Does the person have potential to be independently mobile in and around the facility? ☐ No ☐ Yes

Please indicate: ☐ Self-propelling ☐ Punting ☐ Power

If a powered wheelchair is proposed, is the facility open to residents utilising powered mobility within their setting? ☐ No ☐ Yes

Alternatives considered where proposed long term solutions will be a transit wheelchair

Please outline the static seating solutions available (lazy boy, care chair etc.) in the residential care setting:

Please indicate why this static solution cannot be utilised to provide the person with a safe seated position for meals, communication and social interaction:

Please outline the wheeled mobility options available in the residential care setting:

Please indicate why these wheeled mobility solutions (self-propelling or transit wheelchair) cannot be utilised to provide the person with safe mobility in and around the facility e.g. from room to lounge:

Health and other considerations

Does the person have a current pressure injury or at risk of skin breakdown? ☐ No ☐ Yes

Has a skin integrity management plan been identified? ☐ No ☐ Yes Please advise:

Has an aspiration management plan been identified? ☐ No ☐ Yes Please advise:

Other health issues (health, impairment, function):

Office use: Administration please print referral, affix correct patient label for scanning and upload referral to RCP.