

# POSTURE & MOBILITY SELF-REFERRAL FORM

**CONFIDENTIAL**

## Leicester Posture & Mobility Services

### Instructions:

- Please only complete this form if you are an existing patient. If you are not yet registered with us, please contact your healthcare professional
- Please complete all sections. Failure to do so will result in the referral being rejected and returned for full completion. This will delay the processing of the referral
- Please email the completed form to: **opcare.wheelchairservices@nhs.net**

1. Patient details						<i>Must be fully completed</i>	
Title:		Forename:		Surname:			
Date of birth:		Gender:		NHS number:			
Address:						Post code:	
Home tel:				Mobile:			
Email:							
Interpreter required?	No	<input type="checkbox"/>	Yes, for the following language:				

2. General Practitioner details				<i>Must be fully completed</i>		
GP name:				GP number:		
Address:					Post code:	
Main tel:				Email:		

3. Medical details		<i>Must be fully completed</i>
Medical condition:		
Reason for referral:	Please state which wheelchair/equipment you would like us to review and the reasons why. Please provide as much detail as possible in order to avoid any delays to processing your referral.	

