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POSTURE & MOBILITY SELF-REFERRAL FORM

CONFIDENTIAL

Staffordshire 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

Must be fully completed

Title:		Forename:		Surname:	
Date of birth:		Gender:		NHS number:	
Address:				Post code:	
Home tel:		Mobile:			
Email:					
Interpreter required?	No		Yes, for the following language:		

2. General Practitioner details

Must be fully completed

GP name:		GP number:			
Address:				Post code:	
Main tel:		Email:			

3. Medical details

Must be fully completed

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.

Address: Clifford Street, Hanley, Stoke-on-Trent, Staffordshire, ST1 3EN
Tel: 01782 216 940 | **Email:** opcare.wheelchairservices@nhs.net | **Web:** www.opcare.co.uk

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4. Existing equipment details *Must be fully completed*

Equipment type (e.g. transit, self-propelled, powered):
Equipment model (e.g. Action 3, Spectra, Rea Azalea):
Asset number (this should be located on a sticker on the lower area of the equipment):

5. Consent and authorisation *Must be fully completed*

Do you consent to us sharing information with other healthcare providers as needed?				
Yes		No		
Would you like to be kept informed via email?				
Yes		No		
Would you like to be kept informed via text messaging ?				
Yes		No		

6. Additional information

Please provide any additional information you believe may assist with, or be essential to, this referral.

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