chailey heritage clinical services

Sussex Community NHS
NHS Trust

Instructions:
You can either print this form for completion and post it to the address at the foot of the page or save this form on your computer, type the required information in the grey boxes and securely e-mail it to: SC-TR.enquirieschcs@nhs.net

Posture Clinic Referral Form (Form PCR1)

1	**Client Details**	
	Surname: **D.O.B:** **First Name:** **Address:** **Post Code:** ☎:	**Weight:** (if known) **Height:** (if known) **Male:** ☐ **Female:** ☐
2	**Next of Kin**	
	Relationship: **Address:** ☎: **Mobile no:**	**GP:** **Address:** ☎:
3	**Details of Professionals involved**	
	Physiotherapist: **Address:** ☎:	**Occupational Therapist:** **Address:** ☎:
4	**Wheelchair Service**	
	Address: ☎:	
5	**Medical/ Referral Details**	
	Please state the client's primary diagnosis? Please state any further diagnoses that the posture clinic team should be aware of?	
	Briefly describe the client's posture and any changes in movement, quality of movement and/or tone?	
	Please list hip and spinal surgery in the last 5 years, and other relevant surgery:	

6	**Reason for referral to CHCS**
	Please state your reason for referring this client:
	Why do you need our services?
	Please let us know if there are any vision, hearing, tissue trauma or pain issues:
	Please list any other posture/seating clinics attended in last 2 years or pending:
7	**Equipment Details**
	What pieces of postural management equipment have you found helpful e.g. seating and mobility equipment static seating, standing frame, night positioning:
	What pieces of postural management equipment have you not found helpful?
	Who provided the equipment listed in question 7 ?
8	**Funding and agreement**
	Please send completed form PCR2 to the therapist at the client's relevant wheelchair service for completion and return to Chailey. *Some wheelchair services do not provide special seating to children under 3 years old. If your client is under 3 years old please contact the wheelchair service to find out about funding arrangements.* *If the wheelchair service will not be funding the seating system and wheelchair please state who the invoice should be sent to:* Name: Position: Address: ☎:
9	**We will send the appointment letter to the client, the referrer and the wheelchair service; is there anyone else you would like the appointment letter sent to, please state?**
10	**Referrer details**
	Name: Position: Address: ☎: Signature: Date:

Important: Once completed please return this form to the posture clinic coordinator at Chailey Heritage Clinical Services at the address below, or securely e mail it to SC-TR.enquirieschcs@nhs.net If you have any questions please contact the posture clinic coordinator.

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Form PCR 2

Date:
To: Wheelchair Service

Address:

Dear Sir/ Madam

Re: Name of Client: DOB:

The above named client has been referred to a posture clinic at Chailey Heritage Clinical Services. As part of this clinic, seating will be assessed. As a result of this, new or alternative equipment may be required.

Please could you indicate, by ticking the boxes below, the agreement that you will provide following the clinic outcome?

- **No Assessment** ☐

No seating assessment required at Chailey Heritage Clinical Services.
All seating and wheelchair needs are being met by another service.

- **Assessment only** ☐

The Wheelchair Service will not fund any equipment prescribed through this clinic.

- **Assessment and provision** ☐

Funding of wheelchair and/or seating will be provided by the Wheelchair Service.
Following the clinic a quote will be sent to you and the costs agreed before provision takes place.

Any Other Comments:

Name:

Signature: Date:
(Wheelchair Service Manager)

Wheelchair Service:

Once completed, please return this PCR2 letter to the posture clinic coordinator at Chailey Heritage Clinical Services (address below). If you have any questions please contact the posture clinic coordinator on the telephone number below.