**Somerset GP Referral Form for Wheelchair Assessment**

**Referral for Wheelchair Assessment from Dr:**

Please use practice stamp or print full name, address and telephone number

**Please assess the following patient for a wheelchair:**

Surname: Title: Mr. Mrs. Miss. Ms

Forename: Date of Birth:

Home Address: NHS Number (if known):

Postcode: Telephone:

**Height: Weight:**

**Disability / Medical Condition:**

Please indicate below how the chair will be propelled – tick all boxes that apply

Client Attendant Powered

How many days a week will the chair be used indoors?

Please circle 0 1 2 3 4 5 6 7

How many days a week will the chair be used outdoors?

Please circle 0 1 2 3 4 5 6 7

**GP Signature Date**