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| **MOVING AND HANDLING TEAM REFERRAL FORM** |
| **Swift ID** | **NHS Number** |
| **Name: Mr/Mrs/Miss/Ms/other** | **DOB** |
| **Address****Postcode:****Tel:** | **Next of kin:** relationship:Name:Address:Contact number: |
| **Involvement from other professionals:** |
| **GP: Practice:****Tel:** |
| **Ethnicity:** | **Religion:** | **Language:** |
| **Is an interpreter needed? YES/NO** |
| **Property type:** |
| House [ ]  | Bungalow [ ]  | Ground floor flat [ ]  |
| Upstairs flat [ ]   | Bedsit [ ]  |  |
| **Property tenure:** |
| Owner Occupied [ ]  | FCHO [ ]  | Housing 21 (Oldham) [ ]  |
| Housing Association [ ]  | Privately Rented [ ]  | Residential/Nursing home [ ]  |
| **Current medical problems:** | **Medical history:** |
| **Allergies:** | **Consultants:** |
| **Any risks to staff visiting client at home?**  |
| **Any** **continence issues:** |
| **Referred by: Relationship: Contact no:****Address: Date:***Duty Officer:* |

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| **Name:** | **Swift ID:** | **NHS Number:** |
| **Address:** |
| **Other members of household:**

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| --- | --- | --- | --- |
| Name: | Age | Male/Female | Relationship |
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| **Who does the majority of the manual handling for the person?** | **Formal staff** (agency, P.A’S, nursing home staff)  [ ]   | **Informal staff** (family, friends)  [ ]  |
| **Agency/organisation involved –** | **Contact number -**  | **How many visits per day and times of visits -** |
| Has the agency/organisation’s manual handling facilitator assessed the person?Yes [ ]  No [ ]  | If no please give reasons why not -  | If yes please give details of what they recommended –  |

**Is the referral for – (please tick as many boxes that apply) –**

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| Assessment of transfers in and out of chair | [ ]  | Assessment of transfers in and out of bed | [ ]  | Repositioning in bed  | [ ]  |
| Mobility assessment | [ ]  | Assessment going up/down stairs | [ ]  | Assessment to increase/reduce staff | [ ]  |
| Sling does not fit correctly | [ ]  | Sling not suitable for the person | [ ]  | Sling needs replacing due to wear and tear | [ ]  |
| Assessment of current bed | [ ]  | Requires glide sheets | [ ]  | Requires wedges | [ ]  |
| Assessment for a mobile hoist | [ ]  | Assessment for ceiling track hoist | [ ]  | Assessment for a standing hoist | [ ]  |
| Assessment for a rota stand | [ ]  | Seating assessment | [ ]  | Assessment for a bath seat / shower chair | [ ]  |
| Requires Glide about commode | [ ]  | Requires a static commode | [ ]  | Requires a toilet frame | [ ]  |
| Requires a walking frame | [ ]  | Requires grab rails | [ ]  | Requires a handling belt | [ ]  |
| Requires a leg lifter | [ ]  |  |  |  |  |

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| **Name:** | **Swift id:** | **NHS number:** |
| **Address:** |

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| **What mobility does the person have? (any equipment used)** |
| **Wheelchair user (indoors/outdoors/manual/powered)** |
|  | **Explain the current problem** | **What is the current set up i.e. is any equipment already in situ? Has the bed been brought downstairs? etc** |
| Stairs/stair lift*(how many banisters, straight/curved staircase, ability to use the stairs or transfer onto stair lift))* |  |  |
| Toilet*(transfers on/off, height, rails, position, hoist used, which slings etc)* |  |  |
| Bed*(type – divan/ frame with slatted base? Height, single/double /kingsize)**Is a bedrail risk assessment needed?* |  |  |
| Chair*(type, height etc)* |  |  |
| Personal Care *(washing and dressing)*Environmental issues (lack of space, poor flooring etc) |  |  |
| **Name:** | **Swift ID:** | **NHS number:** |
| **Address:** |
|  | **Explain the current problem** | **What is the current set up i.e. is any equipment already in situ? Has the bed been brought downstairs? etc** |
| Bath*(transfers, shape, rails, overbath shower in situ?)* |  |  |
| Bedroom, (access, space) |  |  |
| Access*(number of steps, obstructions, rails in situ)* |  |  |
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**Incomplete forms will be returned, and the referral will not be accepted until there is sufficient information provided.**

**When sending in this referral please ensure you attach the completed manual handling risk assessment**