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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:**   |  |  |  |  | | --- | --- | --- | --- | | Name: | Age | Male/Female | Relationship | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | | | | | |
| |  |  |  | | --- | --- | --- | | **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) –**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 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 |  |  |  |  |  | | | | | | |
| |  |  |  | | --- | --- | --- | | **Name:** | **Swift id:** | **NHS number:** | | **Address:** | | | | | | | | |
| **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)* |  | | | |  |
|  |  | | | |  |

**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**