# Wheelchair & Seating Outreach Service Referral & Outcome Summary

## Referral for Outreach Clinic – Completed by EMS Assessor

[ ]  Wheelchair & Seating

[ ] Lying Supports/Positioning

**Type of clinic appointment** Choose an item **If In Person, please give rationale** Enter text

**Date of referral** Enter a date

**Preferred clinic date** Enter a date

**Preferred time** Enter text **Impossible times** Enter text

**Venue/address for clinic appointment** Enter text **Preferred method of contact:** Choose an item.

**Technician required?** [ ]  Yes [ ]  No

### Person’s Details

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Name** | [Insert Family Name] | **First Name(s)** | [Insert First Name(s)] |
| **NHI** | [Insert NHI] | **Date of Birth** | Enter text |
| **Address** | Enter text | **Email** | Enter text |
| **Gender** | Choose an option | **Ethnicity** | Enter text |

### EMS Assessor Details

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Enter text | **AEA No.** | Enter text |
| **Phone** | Enter text | **Accreditation** | Choose an item |
| **Email** | Enter text |

### Eligibility Details

**Primary Diagnosis** Choose an item **Coexisting condition or other:** Enter text

**Resides:** Choose an item **If not listed, please state**: Enter text

**Funding Stream** Choose an item

### Explanation of Situation

**Background Information** (e.g., person’s social & living situation, roles, relevant history, services or supports)

Click or tap here to enter text.

**Current Functional Ability & Physical Findings** (e.g., person’s current equipment, range of motion)

Click or tap here to enter text.

**Current Issues/Challenges** (e.g., strengths, functional limitations/disability)

Click or tap here to enter text.

**Person’s Goals or Aspirations**

Click or tap here to enter text.

**Proposed Solution** (list your specific or preferred options if known)

Click or tap here to enter text.

### Include Attachments (where applicable)

|  |  |
| --- | --- |
| * Photos or video
* Power wheelchair specification form
* Manual specification form
* Completed physical assessment form
 | * Confirmation of LTS-CHC funding
* Evidence of main carer
* Evidence of full-time tertiary study
* Evidence of voluntary work
* Evidence of full-time employment
 |

## Outcome of Consultation - Completed by Clinical Services Advisor, Outreach

### Appointment Details (e.g. clinic date, attendees etc)

Click or tap here to enter text.

### Goals

Click or tap here to enter text.

### Consultation Notes/Advice (e.g. new discussion points etc)

Click or tap here to enter text.

### Any Unmet Needs

Click or tap here to enter text.

### Outcomes and Recommendations (include equipment considered for trial)

Click or tap here to enter text.

### Plan (e.g. future actions, next steps, review etc)

Click or tap here to enter text.

[ ] Solution meets Disability Support Services (DSS) access criteria, consider proceeding to the DSS|EMS Portal

[ ] Solution does not meet DSS|EMS access criteria, consider alternative solutions

[ ] Other: Enter text

**Date Completed** Enter a date

**Clinical Services Advisor** Choose an item

**Designation** Choose an item

Click on the icon below to paste in any photos

  

 