Oxford University Hospitals
NHS Foundation Trust

SPECIALIST DISABILITY SERVICE
REFERRAL FORM – MOBILE ARM SUPPORT (MAS)

Oxford Centre for Enablement, Windmill Road, Headington, Oxford, OX3 7HE
T: 01865 227 447 | specialist.disabilityservice@ouh.nhs.uk

Please ensure funding of the equipment is obtained prior to completing this referral form. The Specialist Disability Service is unable to provide any appointments until funding has been agreed.
For more information regarding the Mobile Arm Supports, potential, but not guaranteed, funders, and a list of areas with an established Service Level Agreement (SLA), please visit our website:
Specialist disability services referrals - OCE (ouh.nhs.uk)

CLIENT'S DETAILS						
Full name:					Title:	
Address:				Telephone no:		
				Mobile no:		
NHS no:		Date of birth:		Email:		
Diagnoses:					Height:	
					Weight:	
Other relevant medical details (e.g. planned surgery, tissue status):						
Consent gained from the client for this referral:		Yes ☐		No ☐	Best interest ☐	
GP (name and initial)*:						
Name/place of practice:						

** Essential information to identify CCG before referral is processed.*

Please note: If the GP does not have an established Service Level agreement (SLA) with us, you will be required to provide us with the appropriate CCG information to request for funding.

OTHER RELEVANT PROFESSIONALS INVOLVED (as applicable)		
Name and profession	Contact detail	Involvement

PLEASE INDICATE WHETHER THE PATIENT HAS ALREADY BEEN REFERRED FOR ANY OF THE FOLLOWING:			
Wheelchair Seating	☐	Mounting of electronic assistive technology	☐
Computer Access	☐	Communication aid	☐

Detailed reason for referral, including aims of intervention *(please provide sufficient information to allow appropriate prioritisation):*				
Other relevant information:				
Details of home/day care arrangements:				
Level of mobility: (include type of equipment used)	Indoors:			
	Outdoors:			
Method of transfer: (Equipment used)				
Care needs:				
Ability to communicate and method of communication:				
Indicate means of transport to appointment:	Own/home vehicle		Ambulance	
If a home visit is required, please provide:	A brief rationale			
	Access details			

REFERRER DETAILS			
Referred by:		Job title:	
Address:		Email:	
		Mobile:	
		Office:	
Signed:		Date of referral:	

Please return completed form to Specialist Disability Service, The Oxford Centre for Enablement, Nuffield Orthopaedic Centre Windmill Road, Headington, Oxford OX3 7HE, specialist.disabilityservice@ouh.nhs.uk (preferred route).