Sent/Initials……

QEF Mobility Services
1 Metcalfe Avenue, Carshalton
Surrey, SM5 4AW
Tel: 020 87701151
Fax: 020 8770 1211
Email: mobility@qef.org.uk
www.qef.org.uk

Please fill in all boxes on the application form.
We need this information to provide you with our services, and although data may be shared for healthcare purposes, vital interests, legal reasons, or public interest, it will not be shared for marketing purposes without your explicit consent. For more detailed information on how we process your data and keep it secure, you can visit our website at www.qef.org.uk.uk/privacy/ or contact the office email or phone.

Children's Application Form

(USING CAPITAL LETTERS, PLEASE RETURN THIS COMPLETED FORM AS SOON AS POSSIBLE AS WE ARE UNABLE TO BOOK APPOINTMENTS WITHOUT IT)

For office use only:

Reason for application – please tick left hand box:		
	Vehicle Transfer and Seating Assessment including car seats and wheelchair accessible vehicles	£264.00
	Wheelchair Assessment including buggy, manual wheelchair and powered wheelchair	£264.00

1. About the child…	
First name:	Surname:
Date of birth: / /	Male/Female
Address: Postcode:	
Weight:	**Height:**
Does the child receive the higher rate mobility component of the Disability Living Allowance (or enhanced element of the Personal Independence Payments)? ☐ **Yes** ☐ **No**	
Medical Diagnosis/es:	
What difficulties does your child have?	

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2. About the parent/carer of the child…	
First name:	Surname:
Email:	Phone number:
Address (if different from above):	What is your relationship to the child being referred?
3. About the child's therapist(s)…	
First name:	Surname:
Email:	Phone number:
In what capacity does this therapist see the child?	
First name:	Surname:
Email:	Phone number:
In what capacity does this therapist see the child?	
4. About the assessment – please fill in the sections that you can about your car seat/car/wheelchair/buggy…	
What make and model is your current equipment/vehicle?	
What age is your current equipment/vehicle? Please provide details of time left on lease (as appropriate)	
Where is the equipment/vehicle usually stored/parked?	

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What difficulties are you experiencing with your current equipment/vehicle?
Are there any products you have seen that you would particularly like considered at the appointment?
What outcome would you like from attending an appointment?
5. Declaration of consent
I understand that my child will be assessed and measured by the assessment team at QEF Mobility Services. **YES/NO** I understand that the assessment may involve some manual handling to access any relevant equipment. **YES/NO** I understand that the information on this referral form can be shared with other relevant agencies (dealer and equipment supplier) and professionals who need to know my child's circumstances. **YES/NO** I understand I have the right to withdraw from the assessment at any time. **YES/NO** I understand that there will be a 25% administration fee charge for all cancellations if another appointment is not required. **YES/NO** I understand that if I fail to attend the appointment, or do not complete the assessment or if I do not give at least 7 days cancellation notice, the fee will not be refunded. **YES/NO** I understand that staff may record images during assessments to provide additional content to the written report. **YES/NO** I give consent for QEF Mobility Services to contact my doctor, if considered necessary, for any further medical information relevant to this assessment, which will be treated in strict confidence. **YES/NO**
Signature of parent/guardian:
Name in capitals:
Relationship to young person:
Date:

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CLIENT NAME: ……DATE OF BIRTH ……/……. /…….

If you are over the age of 13 and wish for someone to act or speak on your behalf, please complete their contact details below.

Individual 1

Name: ……Relationship to client……

Address……
……Postcode:……

Mobile……Email……

Please indicate when you would like QEF to contact the person named above: -

To make appointments on my behalf	YES □	NO □
To discuss progress, recommendations and outcomes	YES □	NO □
To make payments	YES □	NO □

Individual 2

Name: ……Relationship to client……

Address……
…… Postcode:……

Mobile……Email……

Please indicate when you would like QEF to contact the person named above: -

To make appointments on my behalf	YES □	NO □
To discuss progress, recommendations and outcomes	YES □	NO □
To make payments	YES □	NO □

Client signed …… Name……..…… Date…….

Sent/Initials……..

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EQUAL OPPORTUNITIES DATA

We are obliged to ask this information from the organisations that fund our service.

You do not have to answer these questions, and if you choose not to, this will not make any difference to the service you receive.

Ethnic Origin:

Asian Bangladeshi ( ) Asian Indian ( ) Asian Other ( ) Asian Pakistani ( )

Black African ( ) Black Caribbean ( ) Black Other ( ) Chinese ( )

Mixed Other ( ) Mixed White + Asian ( ) Mixed White + Black African

Mixed ( ) Mixed White + Black Caribbean ( )

White British ( ) White Irish ( ) White Other ( )

Ethnic Other ( ) Please specify_____

Declined to comment ( )