Southern Health NHS
NHS Foundation Trust

Tissue Viability Service Referral Form

<table>
<tr><td>

DATE:

Patient Details: (please print)
Name:
Address:

D.O.B:

Tel. No: **Mobile No:**

NHS No: (essential)

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Details of Referrer: (please print)
Name:
Base
Fax No:
Mobile No
E-mail
Please tick:
CCT **Mental Health**
Practice Nurse **LD**
Nursing Home **Other -**

Has patient given permission to share YES/NO
Has patient agreed to this referral? YES/NO
Consent to view the patient's HHR. YES/NO

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GP Details:
Name:

Surgery:

</td><td>

Tel. No:

Fax No:

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Significant Clinical / Medical History:
e.g.Chronic diseases, significant illnesses and operations.

General:
Diabetes (Type)
Cardiovascular Disease
Rheumatic/auto-immune conditions
CVA (Stroke)
Fully Mobile
Wheelchair user
Current BMI:

Known allergies (please list)

MRSA (if known) Negative / Positive
Date of last screen.

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Current Medication

Current Specialties seen:
(Eg.Vascular, Dermatology, Elderly Care)

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Reason for referral to Tissue Viability Service:
(circle / tick all relevant and add any other)

- Not responding to current past/treatment regimes
- Pain
- Lifestyle/co-morbidities affecting healing (state what)
- Sensitivities to dressings
- Unresolved infection/critical colonisation
- Complexity of wound/s
- Skin problems ie Maceration

***Full Blood Count must be taken prior to referral and sent with or after referral ready for assessment**
****(Attach photocopy of Leg Ulcer/Wound Assessment Form with referral***

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Current Dressings/ Bandage /Treatments including creams, ointments, dressings, bandages etc

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Complete one section only:

Wound/Pressure Ulcer:

Sites

Duration(in weeks):

Size(in cms):

Wound History

Pressure Ulcer Classification
(EUPAP grading system 2009)
http://www.epuap.org/gltreatment.html#top
Grade 1
Grade 2
Grade 3
Grade 4
Date graded

Pressure Ulcer Risk Category Score:
Please circle
High **Medium** **Low**

Pressure Risk (date last calculated):

MUST Nutrition Score (date last calculated):
http://www,bapen.org.uk/must_tool.html

Pressure Ulcer Relieving Equipment in place:

Leg Ulcer:

Leg Ulcer/Limb problem: Left/ Right / Bilateral
(*circle one*)

Site/s:

Duration(in weeks):

Size(in cms):

Ulcer History

Lower Limb Arterial Status: Doppler
Date last Doppler done:

If not undertaken what are the reasons.

By:

Designation:

Systolic	Left ABPI	Right ABPI	Arterial Sounds (must be recorded)
Brachial			Left Right Triphasic Biphasic Monophasic Uncertain/ Unobtainable
Dorsalis Pedis			
Posterior Tibial			
ABPI			*If last 2 boxes ticked orABPI below 0.8 ,contact the Leg Ulcer Service by telephone to discuss urgency of referral*

Form completed by: **Designation:**

Please contact the team if there are any risks to staff at the property to be visited

Please e-mail to:hp-tr.clinicaladmin@nhs.net

Referrer will be contacted with appointment details

BOTH PAGES TO BE COMPLETED

Date referral received: **Date & Time of arranged visit:**

Printout of Medical Summary is always required