**Tissue Viability Specialist Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Contact Details for the services | | | | | | | | | | | | |
| Email | | Hampshiretvteam@southernhealth.nhs.uk | | | | | | | | | | |
| Address | | Room 115 Eastleigh Health Centre, Newtown Rd, Eastleigh, SO50 9AG | | | | | | | | | | |
| Telephone | | 0300 373 0211 | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Patient’s details | | | | | | | Patient’s background and culture | | | | | |
| Name | Full Name | | | | | | Ethnicity | | Ethnic Origin | | | |
|  |  | | | | | | 1st language | | Main Language | | | |
| DOB | Date of Birth | | | Age | Age | | Interpreter required? Interpreter required | | | | | |
| Sex | Gender(full) | | | | | | Military Veteran? | | | | | |
| Address & postcode | Home Full Address (stacked) | | | | | | Referrer details | | | | | |
|  |  | | | | | | Referring Clinician | |  | | | |
|  |  | | | | | | Address | | Organisation Name  Organisation Full Address (stacked) | | | |
| NHS No | NHS Number | | | | | | Tel no | | Organisation Telephone Number | | | |
| Hospital No | Hospital Number | | | | | | Email | | Organisation E-mail Address | | | |
| Home tel | Patient Home Telephone | | | | | | Referral date | | Short date letter merged | | | |
| Work tel | Patient Work Telephone | | | | | | Date received | |  | | | |
| Mobile tel | Patient Mobile Telephone | | | | | |  | |  | | | |
| Email | Patient E-mail Address | | | | | |  | |  | | | |
| Preferred contact method | | | Home | | |  | Work |  | Mobile |  | E-mail |  |

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| **Social Information** | | | | |
| Social Context | Transport Issues | Has a Carer | Is a Carer | Lives Alone |
| Next of Kin |  | | | |
| Relationship to Patient |  | | Telephone No |  |

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| **Reason for referral**  \*The TVNS team will triage all referrals and make contact with the referrer  **Reason for referral:** (please tick all relevant) |
| |  |  |  |  | | --- | --- | --- | --- | |  | Category 4 pressure ulcers  (except intact black necrotic heels) |  | Lifestyle/co-morbidities affecting healing  (state what) | |  | Fungating wounds |  | Pain | |  | Rapidly deteriorating wound |  | Sensitivities to dressings | |  | Bone/tendon exposed |  | Unresolved infection/critical colonisation | |  | Wound larger than 10x10cm |  | Complexity of wound/s | |  | Not responding to current/past treatment regimes |  | Skin problems i.e., extensive maceration/ excoriation | |  | Other: (please give brief details) |  | | |  |  |  | | |
| **Are they known to other health professionals?** If so, please list: |
| **Significant Clinical/Medical History: (e.g., Chronic diseases, significant illnesses and operations)**   |  |  |  |  | | --- | --- | --- | --- | | **General -** (please circle as appropriate) | | **Give brief details:** | | | Cardiovascular Disease | YES / NO | Diabetes (type) |  | | Mobility | Bed-bound / Chair-bound / Mobile with Assistance /Mobile | Rheumatic/ auto-immune conditions |  | | Wheelchair User | YES / NO | | MRSA if known  Date of last screen | Negative / Positive | Current BMI |  | | dd/mm/yyyy | Continence Management |  | | Anaemia | YES / NO | MUST Nutrition Score  Date last calculated |  | | dd/mm/yyyy | | Known allergies? (Including dressings) | |  | | | Other Chronic Diseases? | |  | | |

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| **LIST: Current Dressings / Bandage / Treatments** (including creams, ointments, dressing, bandages etc.) |  | |
| **WOUND TYPE: COMPLETE ONE SECTION ONLY** | | |
| **Wound/Pressure Ulcer** | | **Leg Ulcer** |
| **Sites**:  **Duration** (in weeks):  **Size** (in cms):  Wound History  **Pressure Ulcer Category:**  **Date categorised:**  dd/mm/yyyy  **Pressure Ulcer Risk Category Score:**  **Please circle one:** High / Medium / Low  **What Scale was used?** Braden / Waterlow  **Date:**  dd/mm/yyyy  **Equipment in situ?** Please list any pressure relieving equipment being used: | | **Leg Ulcer / Limb problem**: Left / Right / Bilateral  **Sites**:  **Duration** (in weeks):  **Size** (in cms):  Ulcer History  **Lower Limb Arterial Status**: Doppler  **Date last Doppler completed**: dd/mm/yyyy  If not undertaken, what are the reasons?  By:  Designation:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Systolic** | **Left**  **ABPI** | **Right**  **ABPI** | **Arterial Sounds** (must be recorded) | | | |  | **Left** | **Right** | | Brachial |  |  | Triphasic |  |  | | Doralis Pedis |  |  | Biphasic |  |  | | Posterial Tibial |  |  | Monophasic |  |  | | ABPI |  |  | Uncertain/ Unobtainable |  |  | |
|  | | |
| **WOUND PHOTOS ARE ESSENTIAL FOR REFERRALS.**  **PLEASE ALSO ATTACH ANY OTHER SUPPORTING INFOMATION.** | | |
|  | | |
| **PLEASE E-MAIL COMPLETED REFERRAL TO:**  [**hampshiretvteam@southernhealth.nhs.uk**](mailto:hampshiretvteam@southernhealth.nhs.uk) | | |