

## Tissue Viability Services Referral Form

**Please write CLEARLY in BLOCK LETTERS when completing this form.**

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| PATIENT’S DETAILSTitle: (please circle) Dr Mr Mrs Ms Miss Other:**Name:****DOB: NHS No: RIO No:****Address:** **Postcode: Phone:** **Patient’s Borough:** ( please circle) **Enfield Other**  | REFERRER’S DETAILS**Name:****Job Title:****Address:** **Postcode**:**Phone: Fax:****GP’s Name:****Surgery Name:****GP’s Borough:** (please circle) **Enfield**   **Other**  |
| WOUND INFORMATION**Wound type:** (please tick) Leg ulcer[ ]  Pressure ulcer[ ]  **Stage: Pressure relieving equipment in use:** Non-healing surgical wound[ ]  Fungating wound[ ]  Burn[ ]   Diabetic foot wound[ ]  Other[ ] (please specify) **Wound location: How many weeks since wound first appeared?**  |
| **Reason for referral:** |
| **Past medical history (as detailed as possible):** |
| **Past nursing history (include details of past episodes of ulceration, ABPI etc.):** |
| **Current treatment for this wound including dressings and bandages:** | Past treatment for this wound including dressings and bandages: |
| **Current medications and dosage:** |
| PATIENT MOBILITYThe patient: (please tick all appropriate boxes) is fully mobile[ ]  has reduced mobility[ ]  is mobile with aids[ ]  requires a wheelchair but can stand & transfer[ ]  is chair bound and requires hoist to transfer[ ]  is housebound and requires home visit[ ] Ifpatient could attend a clinic, please complete: |
| SIGNATURE OF REFERRER: | DATE: |

Please send form via: **POST:** District Nursing Referral Office, Rowan Court, St Michaels Site, 2 Gater Drive, Chaseside Crescent, Enfield, EN2 0JB.(**Tel:** 020 8702 5910). Or **FAX:** 020 8702 5911 or beh-tr.ECSenfieldlocalityteamsSPA@nhs.net

OFFICE USE ONLY

**Date referral received:** **Does the information provided satisfy referral criteria?** **Yes**[ ]  **No**[ ]

**First appointment details:** am/pm Mon / Tues / Wed / Thurs / Fri / / 20\_\_\_\_\_\_\_

**TVS patient number*: April 2015***