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## Tissue Viability Services Referral Form

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

|  |  |  |
| --- | --- | --- |
| PATIENT’S DETAILS  Title: (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 MOBILITY The patient: (please tick all appropriate boxes) is fully mobile has reduced mobility is mobile with aidsrequires 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](mailto: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***