Tissue Viability Service Referral Form *(May 2024)*

*If you are referring for access to the Cancer Lymphoedema pathway*

*please use the separate Cancer Lymphoedema Service Referral Form.*

*Please note the sections marked with a* \**are mandatory fields and must*

*be fully completed or the referral will be rejected.*

Date of referral: ………………………………………

|  |
| --- |
| **\*PATIENT DETAILS** Name: Address: DOB: Post Code:NHS Number: Telephone Number:  |
| **\*REFERRED BY** Name: Telephone Number: Consultant [ ]  GP [ ]  Specialist Nurse [ ]  Hospital Ward / Speciality [ ]  Practice Nurse [ ]  Community Pharmacists [ ]  Care Home [ ]  Self-Referral [ ]  Other [ ]  Registered GP and Practice: |
| **EXCLUSION CRITERIA** *Referrals received for patients with the following will be declined:-** Patients with Lipoedema and Secondary Lymphoedema and intact skin.
* Patients with a Leg Ulcer:-

- without a manual ABPI recorded or attempted. - with ABPI’s that are between 0.8-1.3 and appropriate compression therapy has not been commenced.* No wounds below the ankle or on the feet.
* Patients aged under 18 years old and those NOT registered to a Barnsley GP practice and / or resident within the Barnsley geographical area.
 |
| **\*INCLUSION CRITERIA** *Please ensure all relevant information is ticked, failure to tick a minimum of one of the following boxes will result in the referral being rejected:-** Must have a wound or be at risk of developing a wound. [ ]
* Must have a Category 3 or 4 Pressure ulcer. [ ]
* Must have a severe moisture associated skin damage. [ ]
* Patients with a leg ulcer:-
* Must have a recent recorded / attempted ABPI Manual and have commenced compression therapy if ABPI’s are between 0.8-1.3 and there is less than 30-40% healing at 4-6 weeks or non-healing after 8 weeks. [ ]
 |
| **PATIENT WEIGHT AND MOBILITY STATUS** *Please complete and tick as appropriate:-*Patients BMI: If BMI >40 has the patient been referred to a dietician? Yes [ ]  No [ ]  Is patient: Fully Mobile [ ]  Chair Bound [ ]  Bed Bound [ ]  Will the patient be able to apply & remove compression hosiery? Yes [ ]  No [ ]  If not, is social help in place if required? Yes [ ]  No [ ]  |
| **\*REASON FOR REFERRAL** *Please tick the primary reason for referral:-* Pressure Ulcer and or Leg Ulcer (please provide additional information below) [ ]  Skin Tear [ ]  Fungating Wound [ ]  Surgical Dehiscence requiring Topical Negative Pressure [ ]  Lymphoedema with Ulceration [ ]  Severe Moisture Associated Skin Damage [ ]  Other (e.g. rapidly deteriorating wound) [ ]  |
| **FURTHER INFORMATION** *Please provide description of the wound / pressure ulcer / leg ulcer including any recent photographs:-* |
| **PAST MEDICAL HISTORY / DISABILITIES**  |
| **MEDICATION** |