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: ………………………………………

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| **\*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** |