**TISSUE VIABILITY REFERRAL FORM**

**Have you consulted the Wound Management Formulary for advice in the first instance?**

 [**WOUND MANAGEMENT FORMULARY**](file:///V%3A%5CWound%20Management%5CWound%20Formulary%20April%202018) or Tissue Viability Website

<https://staffnet.fv.scot.nhs.uk/a-z/nursing/assuring-better-care/campaigns/tissue-viability/>

***PLEASE ATTACH WOUND PHOTOGRAPHS AS APPROPRIATE TO THIS REFERRAL***

***SEND COMPLETED REFERRALS TO:*** **fv.tissueviability@nhs.scot** **(preferred method) or post Tissue Viability Service, Falkirk community Hospital, Major’s Loan Falkirk FK1 5QE**

**INSTRUCTIONS: ALL referrals require completion of page 1 followed by the section/s relevant to your referral.**

 **Wound referrals** complete section 1

**Pressure related problems (including friction/shear)** complete section 2 (**AND** section 1 if pressure ulcer present)

**Chronic oedema/Specialist Hosiery** complete section 3 (**AND** section 1 if a wound present)

**Skin Problems – Including moisture damage and IAD** complete section 4

|  |
| --- |
| **PATIENT INFORMATION** |
| NAME |  | **D.O.B** |
| **CHI:** |
| **ADDRESS & POSTCODE** |  |
| **G.P. NAME & ADDRESS** |  | **Consultant** |

DATE:

**Referrer’s details or person to contact with regards referral**

|  |  |
| --- | --- |
| Name |  |
| Contact Number |  |
| Email Address |  |
| Base |  |
| Role |  |

|  |  |
| --- | --- |
| **Reason For Referral to TVS** |  |
| PMH:IF AN INPATIENT IN ACUTE /COMMUNITY HOSPITAL – REASON FOR ADMISSION | MEDICATION/ALLERGIES |

 **SECTION ONE – WOUND**

 ***PLEASE ATTACH A PHOTOGRAPH OF THE WOUND TO RELEVANT REFERRAL (if not on Morse)***

**WOUND TYPE (e.g. leg ulcer, trauma, surgical wound, haematoma, skin tear):**

**IF A VENOUS LEG ULCER IS THE PATIENT ON THE VLU PATHWAY? Yes No**

**WOUND DURATION: WEEKS MONTHS YEARS**

**Anatomical Location:**

**Please mark the position on the body map below**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **WOUND DIMENSIONS** (MM/) | **LENGTH** |  | **WIDTH** |  | **Depth** |
| **WOUND BED** **Complete in %** | **NECROSIS/BLACK** | **SLOUGH/YELLOW**  |
| **GRANULATION/RED** | **EPITHELIALISING/PINK** |
| **HYPERGRANULATION** | **ANY UNDERMINING TRACKING?** **Length/ Depth (mm)** |
| [**Refer to Exudate Pathway**](file:///V%3A%5CWound%20Management%5CYVONNE%5Cexudate%20pathway.pdf)**EXUDATE LEVEL** | **SATURATED/LEAKING** | **WET** | **DRY/MOIST** |
| **EXUDATE TYPE**[**Refer to Exudate Pathway**](file:///V%3A%5CWound%20Management%5CYVONNE%5Cexudate%20pathway.pdf) | **CLEAR/****STRAW** | **RED/PINK** | **Cloudy/milky/creamy** | **Green/Yellow/****Bluish??** | **Yellow/brown** |
| **ANY CLINICAL SIGNS OF INFECTION?** | **IF YES****STATE:** |  |  | **SWAB TAKEN?****WHEN:** | **RESULT:** |
|  **PAIN PRESENT? NOCICEPTIVE? NEUROPATHIC?**  | **Scale: 0 1 2 3 4 5** | **Current Management?** |
| **NUTRITION: WEIGHT KG MUST SCORE****BMI:**  | **Current Management?** |
| ABPI RESULT AS APPROPRIATE FOR LEG ULCER | Manual OR Automated Machine  |
| Left ABPI | Right ABPI |
| **MOBILITY : FULLY RESTRICTED** | **MOBILITY IMMOBILE BED/CHAIR /WHELCHAIR BOUND** |

|  |  |
| --- | --- |
| **PAST WOUND TREATMENTS AS APPLICABLE** |  |
| **PRESENT WOUND TREATMENT REGIME AND HOW LONG IN USE** |  |

|  |
| --- |
| **What is the patient’s attitude/behaviour towards their current treatment/management?** |

**SECTION 2 – PRESSURE RELATED PROBLEMS (Including Shear/Friction)**

Is there current pressure damage?

Grade 1 Grade 2 Grade 3 Grade 4 DTI Ungradeable

Has there been any previous pressure damage? Grade:

Please mark the position on the body map below**:**



Pressure Ulcer Risk Assessment -

Braden Score: Other Risk Assessment (Name and /score):

Is Patient mobile: Fully Y/N Restricted Y/N Indicate any Mobility Aids used: Bed Bound

|  |  |  |
| --- | --- | --- |
| **Surface: What is the patient currently:** | **Sitting On**? (bed/chair/riserrecliner/sofa etc) | Cushion: |
| **Sleeping On**? bed/chair/riserrecliner/sofa etc)**Offloading Heels?** | Mattress:State:  |
| **Skin Assessment** | Is skin intact Yes/No Comments |
| **Keep Moving** | What is current repositioning regime?Acute Only – Is Care & Comfort Chart in Use Y/N |
| **Incontinence/Moisture** | Any current Issues?State Management Regime: |
| **Nutrition** | Weight: MUST Score:BMI:Current Management as applicable: |
| **MOBILITY** | **FULLY Y/N RESTRICTED Y/N BED/CHAIR/WHELLCHAIR BOUND - CIRCLE** |

|  |
| --- |
| **PLEASE LIST ANY POSTURE OR POSITIONING PROBLEMS, INCLUDING CONCORDANCE** |

|  |  |
| --- | --- |
| **Referrals to Other Services as Applicable** | **Dates** |
| Orthotics |  |
| OT |  |
| Physio |  |
| Podiatry |  |
| Vascular |  |
| Dermatology |  |
| Other eg Wheelchair Service, Dietician |  |

|  |
| --- |
| What is the patient’s attitude/behaviour towards their current treatment/management plan? |

 **SECTION 3- CHRONIC OEDEMA/SPECIALIST HOSIERY**

|  |
| --- |
| **Please list signs and symptoms of chronic oedema/venous disease for the patient e.g. ankle/venous flare, haemosiderin staining, varicose veins, hyperkeratosis, skin folds etc** |

**Limb Measurements (cm):**

**Right ankle Right calf Right thigh (as applicable)**

**Left ankle Left calf Left thigh (as applicable)**

**Leg shape – Normal – Cylindrical - Inverted Champagne Bottle**

 **Abnormal/Other – describe:**

|  |  |  |
| --- | --- | --- |
| **OEDEMA:**  | Yes/No | Pitting - Fibrotic -  |
| **SKIN CONDITION**Please describe: | Current Management: |
| **PAIN**Type: Nociceptive NeuropathicScale: 0 1 2 3 4 5  | Current Management: |
| **MOBILITY:** **Fully –****Restricted –** **Immobile/Bedbound -** | Is the patient sleeping in bed at nightYES/ NOAre they elevating legs during dayYES/NO |
| **Any Other Comments:** |
| **ABPI results if applicable** | **right** | **left** |
| **What is the patient’s attitude/behaviour towards their current/treatment/management?** |
| **What previous management or involvement with other Services has there been? (eg specialist hosiery clinic, Lymphoedema)?** |

**SECTION 4 – SKIN PROBLEMS including IAD, Moisture Damage**

Duration of current skin condition:

Is the patient known to Dermatology? Yes No

|  |  |
| --- | --- |
| Please describe the skin condition | Current Management Regime |

Please mark position on body map below:

 

|  |
| --- |
| What is the patient’s attitude/behaviour towards their current treatment/management? |