**TISSUE VIABILITY REFERRAL FORM**

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

[**WOUND MANAGEMENT FORMULARY**](file:///V:\Wound%20Management\Wound%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**](mailto: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**

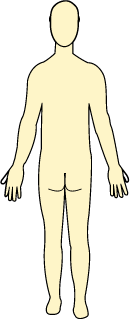
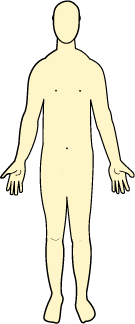
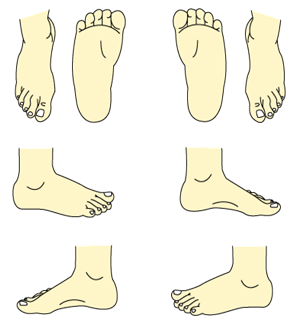
***PLEASE ATTACH A PHOTOGRAPH OF THE WOUND TO RELEVANT REFERRAL (if not on Morse)***

**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:\Wound%20Management\YVONNE\exudate%20pathway.pdf)  **EXUDATE LEVEL** | **SATURATED/LEAKING** | | | **WET** | | | | | **DRY/MOIST** | |
| **EXUDATE TYPE**  [**Refer to Exudate Pathway**](file:///V:\Wound%20Management\YVONNE\exudate%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?** |

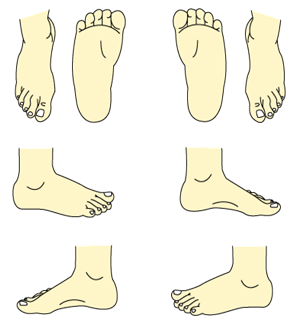
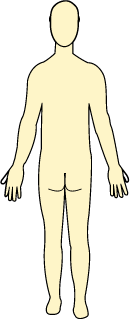
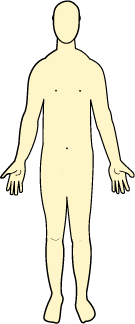
**SECTION 2 – PRESSURE RELATED PROBLEMS (Including Shear/Friction)**

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/riser  recliner/sofa etc) | Cushion: |
| **Sleeping On**? bed/chair/riser  recliner/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 Neuropathic  Scale: 0 1 2 3 4 5 | | | Current Management: | |
| **MOBILITY:**  **Fully –**  **Restricted –**  **Immobile/Bedbound -** | | | Is the patient sleeping in bed at night  YES/ NO  Are they elevating legs during day  YES/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)?** | | | | |

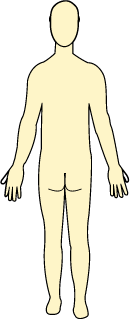
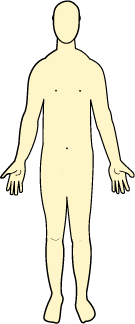
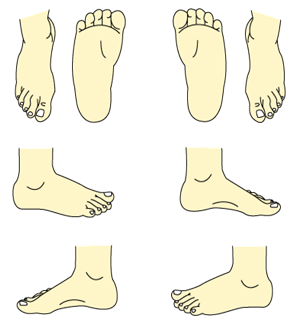
**SECTION 4 – SKIN PROBLEMS including IAD, Moisture Damage**

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? |