[Specialist Hosiery Clinic Referral Criteria](https://staffnet.fv.scot.nhs.uk/departments/wp-content/uploads/sites/16/2023/06/Referral-Criteria-for-Hosiery-Clinic.docx)

**Referrals to be completed by a Registered Healthcare Professional**

**Incomplete or illegible referrals will result in a delay and will be returned**

**HAS NHSFV COMPRESSION THERAPY GUIDANCE FOR LOWER LIMB CARE BEEN CONSULTED PRIOR TO REFERAL?**

[FV Compression Guidance Booklet](https://staffnet.fv.scot.nhs.uk/departments/wp-content/uploads/sites/16/2022/07/Forth-Valley-Compression-Booklet.pdf?rand=p3c784o2lr)

**\* PLEASE ATTACH WOUND PHOTOGRAPHS AS APPROPRIATE TO THIS REFERRAL (if not available on Morse)**

**SEND FULLY COMPLETED REFERRALS TO*:*** [**fv.tissueviability@nhs.scot**](mailto:fv.tissueviability@nhs.scot)

|  |  |  |
| --- | --- | --- |
| **PATIENT INFORMATION** | | **Date:** |
| **Name:** |  | **D.O.B:** |
| **CHI:** |
| **Address & postcode:** |  | |
| **G.P. Name & Address:** |  | **Consultant:** |

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

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PMH:** | | | **MEDICATIONS and any ALLERGIES please list**  **(TVS are unable to access Hepma):** | | | |
| **Is the patient aware of the referral?**  **If no, please state why.** | | |  | | | |
| **Known to Vascular Service?** |  | **Known to Dermatology Service?** | |  | **Known to Lymphoedema Service?** |  |
| **Any Risk to Staff?** | | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please list the signs and symptoms of chronic oedema/venous disease for the patient e.g. ankle/venous flare, haemosiderin staining, varicose veins, hyperkeratosis, skin folds etc** | | | |
| **NUTRITION:** | | **Weight:**  **BMI:**  **MUST Score:**  **Current management as applicable:** | |
| **LEG SHAPE – Cylindrical / Inverted Champagne Bottle:**  **Abnormal/Other – describe:** | | | |
| **Limb Measurements (cm): (as applicable)** | | | |
| **Right ankle:** | **Right calf:** | | **Right thigh:** |
| **Left ankle:** | **Left calf:** | | **Left thigh:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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/able to have been carried out.** | | **Right:** | | **Left:** |
| **AUTOMATED OR MANUAL**  **DOPPLER** | |  | | |
| **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)?** | | | | |