[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**

|  |  |
| --- | --- |
| **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 NeuropathicScale: 0 1 2 3 4 5  | Current Management: |
| **MOBILITY:** **Fully –****Restricted –** **Immobile/Bedbound -** | Is the patient sleeping in bed at night?YES/ NOAre 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)?** |