South Tyneside and Sunderland NHS Foundation Trust

Tissue Viability Community Referral Form (Community)

This must be completed **in full** and sent from **a confidential nhs.net email account** to: stsft.tissueviabilityteam@nhs.net

Patient Details

Name:	NHS No:	D.O.B:
Present Address/Location: Postcode: Telephone:	GP Name and Address: GP Telephone: GP Fax:	
Gender:	Ethnicity:	Religion:
Spoken Language?	Communication difficulties? Y N Interpreter Needed? Y N	
Has the client made any provision regarding treatment under Mental Capacity Act?		Y N

Wound details

(please complete in full tick boxes that apply. If the patient has multiple wounds – please list the details of the 2 largest wounds)

Wound location:	**Wound 1:**	**Wound 2:**
Wound Aetiology: *Please tick one only*	☐ Surgical ☐ Pressure ulcer Cat 3 ☐ Pressure ulcer Cat 4 ☐ Pressure ulcer Unstageable ☐ Skin tear ☐ Other ☐ Venous Leg Ulcer ☐ Mixed Vessel Leg Ulcer	☐ Surgical ☐ Pressure ulcer Cat 3 ☐ Pressure ulcer Cat 4 ☐ Pressure ulcer Unstageable ☐ Skin tear ☐ Other ☐ Venous Leg Ulcer ☐ Mixed Vessel Leg Ulcer
Wound Size/s in mm	Length Width Depth	Length Width Depth
Wound Tissue Type/s	Necrosis/Slough % Granulation % Epithelialisation %	Necrosis/Slough % Granulation % Epithelialisation %

Relevant medical history (tick all that apply)

Diabetes		Anaemia		Immobility		Faecal incontinence	
Heart disease		Dementia		Poor compliance		Identified infection	
Poor blood supply		Anti-inflammatory drugs		Smoking		Low serum albumin	
Poor nutrition		Anticoagulants		Sedatives		Other drugs which affect healing	
Rheumatoid arthritis		Cytotoxic drugs		Urinary incontinence			
Other (please state)							

Allergies:

Current interventions/treatments/dressings/investigations:
(please state current wound management plan and other relevant details)

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Reason for referral to Tissue Viability (e.g. wound static, wound deteriorating etc):
Which other services are involved?(e.g. vascular, podiatry, dermatology). Please provide details:
In which setting does an appointment need to take place? (Please Tick below)

Home Visit	
Wound Hub	
Residential Home	
Nursing Home	
Hospice	
GP Practice	
Tissue Viability Specialist Clinic (BunnyHill)	
Other (please state)	

Referrer Contact Details

Full Name:	Contact Number:
Profession:	Date:
Other details	Has the client consented to this referral? Y N

Please note incomplete referral forms will delay triage and will be returned to the referrer for completion