

TISSUE VIABILITY REFERRAL FORM – INTEGRATED SERVICES

**THIS REFERRAL WILL NOT BE ACCEPTED UNLESS THE FOLLOWING HAS BEEN COMPLETED**

* Check you are referring to the correct specialist service

Do they require foot care (Podiatry), Leg Ulcers (Leg Ulcer Clinic/Vascular), Dermatology, Burns or Plastics

* Use your tissue type guide and dressing formulary

Can this be managed at Community level?

* Follow the Wound Assessment Chart guidance, e.g., weekly assessment, two week dressing rule (**Best Practice**)
* Review by your Patch Leads, Deputy Patch Leads or your Tissue Viability Link Nurse
* Please ensure photography at time of referral

Please note, **ALL** sections **MUST** be completed, otherwise this may result in a delay in patient review.

|  |  |
| --- | --- |
| **Referrer Details** | **Patient Details** |
| Name | Date | Name |
|  |  | Address |
| Team and Location | NHS No DOB |
| Telephone |
|  |  | GP Surgery |
| Team email | HIRS Incident number (if applicable) |

**CLINICAL DETAILS**

|  |  |
| --- | --- |
| **Wound aetiology –** | **Reason for referral** |
| **Wound anatomical location-** |
| **Wound assessment**Dimensions (state cm/mm):Tissue type (using the whole wound as 100%): Infection/Inflammation (Please refer to infection ladder): Moisture balance (exudate levels/ colour)Edges (rolled/irregular):Surrounding Skin (excoriation/maceration): |
| **Duration of Wound** | **Current Treatment plan/duration** |
| **Photography taken****If no, please state why?** | **Yes** | **No** | **Allergies or sensitivities** |
| **Relevant medical History** | **Current equipment** |
| **Relevant medication** | **Safeguarding issues** | **Yes** | **No** |
| **Known/referred to any other services** i.e.) vascular, podiatry, dermatology, Macmillan, plastics | **If you consider this to be a priority, please indicate the reason why.** |

**Please email the completed form** mft.communitytvn@nhs.uk

Tissue viability V2 Review May 2025