# GUYSLOGO COL

# Community Tissue Viability Service Referral Form

**Complete form and email to:** [gst-tr.tissueviabilityservicereferrals@nhs.net](mailto:gst-tr.tissueviabilityservicereferrals@nhs.net).

DATE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT | | | | | | | | | | | | | |
| Patient's Name | |  | | | | | | D.O.B: | |  | | | |
| NHS: | |  | | | |
| Address & Postcode: | |  | | | | | | | | | | | |
| GP Name & Address | |  | | | | | | | | | | | |
| Relevant Medical History  Eg: Diabetes, COPD,PVD, MS, Immobility, End of Life, etc | |  | | | | | | | | | | | |
| WOUND | | | | | | | | | | | | | |
| Site | |  | | | | | | | | | | | |
| Type (please state) | | Pressure Ulcer  (& Stage) | Moisture Lesion | Surgical/  Dehiscence | | Leg Ulcer  (ABPI Date & Result?) | | | | | Fungating | | Skin Tear |
|  | | Other (please state) | |  | | | | | | | | | |
| Wound dimensions (cm) | | Length |  | Width | |  | | | Depth | | |  | |
| Wound bed (%) | | Necrosis/Black | |  | | Slough/Yellow | | | | | |  | |
| Granulation/Red | |  | | Epithelialising/Pink | | | | | |  | |
| Duration of wound | |  | | | | | | | | | | | |
| Present Wound Treatment | |  | | | | | | | | | | | |
| Days patient visited | |  | | | | | | | | | | | |
| Reason for referral | |  | | | | | | | | | | | |
| REFERRER | | | | | | | | | | | | | |
| Name | |  | | | | | Designation | | |  | | | |
| Contact No | |  | | | | | Mobile No | | |  | | | |
| Team & Base | |  | | | | | | | | | | | |
| WE ENDEAVOUR TO CONTACT ALL REFERRERS WITHIN 24 WORKING HOURS OF RECEIPT  OF EMAILED REFERRAL | | | | | | | | | | | | | |
| TVN Office use only | | | | | | | | | | | | | |
| Date Received |  | | | | Date Referrer Contacted | | | | |  | | | |
| Interim advice given |  | | | | | | | | | | | | |