EHS & H&R CCG WOUND CARE REFERRAL FORM

Practice:	**Referred by:**
GP:	**Referrer Contact Number:**
Patient Name:	**Referrer Email:**
Patient Address:	**Consent for referral including transfer of personal data and medical photography?** Yes ☐ No ☐ **Does the person have capacity to give consent? If not, has this referral been completed in the person's best interest?** Yes ☐ No ☐
Patient DOB:	**Referral Date:**
Patient NHS No:	**Patient Ethnic Origin:**
Patient Phone No:	**Urgency of Referral:** Low ☐ Medium ☐ High ☐

WOUND DETAILS

Type of wound:	**Date of Onset:**
Location of wound:	**BMI:**
PRESSURE ULCERS: **Pressure ulcer grade:** 1 ☐ 2 ☐ 3 ☐ 4 ☐ DTI: ☐ Unstageable: ☐ **Waterlow score:** At risk ☐ High risk ☐ Very high risk ☐ **Pressure reducing/relieving equipment** : Domestic Mattress ☐ Static Pressure relieving Mattress ☐ Dynamic Air Mattress ☐ Other ☐ Please specify: Modular cushion ☐ Domestic mattress Static air ☐ cushion ☐ Alternating cushion ☐ Heels offloaded (static air) ☐ Heels placed on the floor ☐ Other : (state) **Mobility**: Bed bound ☐ Chair bound ☐ Fully mobile ☐ Mobile with Aid ☐	**DIABETIC FOOT ULCER** **Grade:** (Texas) _____ Charcot joint**:** Yes ☐ No ☐ Referred to DFU clinic: Yes ☐ No ☐ Previous amputation: Yes ☐ No ☐ Referred to Vascular TVN: Yes ☐ No ☐ Bone /tendon exposed: Yes ☐ No ☐ Multiple ulcer sites: Yes ☐ No ☐ Blood sugars stable: Yes ☐ No ☐ Recent HBA1C:_____
Nutrition: MUST score**:** **Diet :** Adequate ☐ Inadequate ☐ Supplements : Yes ☐ No ☐	
Photograph attached /sent: Yes ☐ No ☐ (referrals will not be processed without images)	**Doppler results :** N/A ☐ Date: Left ABPI= Right ABPI=
Healing Status: Wound healing ☐ Deteriorating ☐ Static > 6wks ☐ Static >12 wks ☐	
Exudate: None ☐ Minimal ☐ Moderate ☐ High ☐ Colour:	
Current Wound Treatment :	

Wound Infection: Yes ☐ No ☐ If yes state infection present (if known):
Wound swab taken: Yes ☐ No ☐ Antibiotics commenced /requested: Yes ☐ No ☐
Other symptoms: Cellulitis ☐ increased exudate ☐ Pain ☐ Malodour ☐ Pyrexia ☐
Other: (state)

Wound bed Condition: (show %)

Healthy granulation(red) _____ Necrosis (black)_____

Hypergranulation(raised)_____ Slough(yellow /grey)____

Other:(state)

Wound Dimensions (cms)

Max length: ☐ Max width: ☐ Max depth: ☐

Undermining/tunelling: Yes ☐ No ☐

Pain: Yes ☐ No ☐ Score 0-10

Score:

Analgesia: (type)

Peri wound/skin : (Tick all that apply): Healthy ☐

Haematoma ☐ oedema ☐ excoriation ☐

Moist/maceration ☐ Dry/flaky ☐

dermatitis/eczema ☐ Other (state)

Medical History (tick all that apply)

Diabetes ☐ Peripheral arterial disease ☐ Rheumatoid arthritis ☐ Malignancy/end of life ☐

State other medical History :

Medications (tick all that apply)

Steroids ☐ Warfarin ☐ Insulin ☐ NSAID,s ☐ Diuretics ☐ Tramadol ☐

Anti hypertensives ☐ Please list all others (including recent antibiotic therapy)

Accessibility information

Does the patient have any communication difficulties: Yes ☐ No ☐ if yes please state requirements:

Symbols ☐ Braille ☐ Sign Language ☐ Large print ☐ Text ☐ Telephone ☐ Link worker ☐

Email ☐ (Email address) Other (please state):

For Office Use Only

Date received:	Date triaged:
Triaged by:	Signature:

Outcome

Domicillary Visit: ☐ Clinic appointment: ☐ Remote Care plan: ☐ Date sent:_____

Appointment Date:_____ Assessment Time: _____ Assessing Clinician : _____

Appointment confirmed with:_____

Special arrangements: Translator Y / N Sign Language Y / N

Communication method: Text ☐ Email ☐ Large Print ☐ Telephone ☐ Symbols ☐

Comments:

Signature: **Name:** **Date:** **Time:**

For EHS CCG send referral & photograph via nhs mail to: ESXCCG.referralswhc@nhs.net
Or for enquiries call Healogics Wound Healing Centre: 01323 735588
For H&R CCG send referral & photograph via nhs mail to: esh-tr.communitytissueviability@nhs.net
Or for enquiries call 01424 735661
For Vascular Nurse referrals: esh-tr.vascularreferrals@nhs.net