WOUND HEALING REFERRAL FORM

NB: INCOMPLETE FORMS WILL BE RETURNED TO THE REFERRER & THIS MAY RESULT IN A DELAY FOR YOUR PATIENT.

Consultant/GP: Address: Tel:	Inpatient referrals (* see below) leave answer phone message for: Ceri Harris (UHW) 46506 Helen Crook (Llandough) 26202	Community referrals fax to: (029) 20932636	Outpatient referrals fax to: (029) 20746334	Referred by (please print full name): Referral Date:

Patient's Name:
Address:

Tel: **DOB: / /**

Referrer's Address:

Tel: **Fax:**

Reason for Referral:

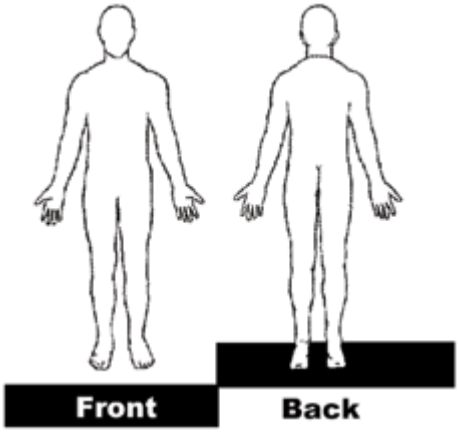
_____
_____
_____
_____
_____

Wound Details: (please tick)

- □ Pressure ulcer Category III & IV
- □ Surgical
- □ Leg ulcer
- □ Extravasation injury
- □ Traumatic wound
- □ Other **(please state)** _____

Duration of Wound:_____

Wound Location:



Mobility: Good [ ] Poor [ ] Chair Bound [ ]
Bed Bound [ ] House Bound [ ]

For Community referrals - does patient require transport? Y / N & Chair / Stretcher **(please circle)**

Previously known to Wound Healing Team? **(please tick)**
Inpatient [ ] Community [ ] Research [ ]
Not known to wound team [ ]

Medical History (including relevant operation details):

Current Medication:
(Please attach repeat script if available)

Other relevant information:

Investigations : (please circle &/or tick)

Plain Films	Y/N	Report attached [ ]
Further Radiology	Y/N	Report attached [ ]
Duplex scan	Y/N	Report attached [ ]
Histology	Y/N	Report attached [ ]
Blood tests	Y/N	Report attached [ ]
ABPI/Doppler	Y/N	Report attached [ ]

Pt Height_____ Pt Weight_____ BMI_____

TO BE COMPLETED BY WOUND HEALING TEAM ONLY

Priority:

Routine	[ ]
Urgent	[ ]
Inpatient review	[ ]
Domiciliary visit	[ ]
Community Clinic	[ ]
General wound clinic/CRI	[ ]
Complex wound clinic/UHW	[ ]
Research clinic	[ ]
Podiatry	[ ]

Signed: Date:

* For **INPATIENTS:** Please ensure 1) Wound Healing Referral Form 2) Medical Illustration of Patient's wound & 3) Wound Assessment Chart have all been completed.