Tissue Viability Referral Form

WE ARE UNABLE TO ACCEPT INCOMPLETE FORMS (boxes with * are mandatory)

nualtra

Patient First Name *:

Patient Last Name *:

Age:

Name of Nursing Home *:

County:

Medications (Steroids, antibiotics, immunosuppressant):

Medical History:

Surgical History:

Allergies (including dressings):

Infection Status:

Continence Status:

Nutritional & Hydration Status:

Mobility Status:
(Bed bound, Chair fast,
Mobile with assistance)

Type of wound:

Duration of wound:

Location of wound:

Measurements (length, width & depth):

Wound Margins(Undermining/Tunnelling):

Wound Bed Description: Peri-wound skin integrity (healthy, fragile, macerated, erythema)

Exudate Volume (scant, low, moderate, and high)

Odour (none, slight on removal of dressing, offensive)

Dressings in use (Primary & Secondary)

Pain: ☐ Yes ☐ No

Name of Nurse making Referral:

Email Address *:

Telephone No.:

Date:

Photos attached: ☐ Yes ☐ No
(Please ensure photos are clear and in colour)

Consent: Please select as appropriate.

☐ I can confirm the resident has consented to the referral

☐ The referral has been made in the residents best interests.