NHS
Bradford District Care
NHS Foundation Trust

Leg Ulcer service LU1

Tissue Viability Service

Name & address (Ward/Service) of referrer:	Title of referrer:
	Mobile number/ward/service ext Number
Please complete all of this form. The TVN team will contact the referrer on receipt of the referral to give advice initially until a clinic appointment is available.	Post Code:
Once the patient has been assessed, shared care between clinicians may still be required.	Date:
	Date of discharge if known.

DETAILS OF PATIENT

Name:	Date of Birth:
Address:	
Post code:	Telephone Number:
General Practitioner/ Consultant	NHS Number:
General Practitioner telephone number:	
Is the patient over 28 stone? (suitable couch & chair available) NO ☐ YES ☐	

Reason for referral	
Duration of wound or current condition	
Current treatment regimen	
Known allergies	
How many limbs require treatment	
ABPI (if known)	
***AWC Patients only* for DVT pathway- if yes give details**	
Is the patient able to transfer (with assistance) on to the treatment couch? YES ☐ NO ☐	

MEDICAL CONDITIONS

Heart failure		P.E.		Limb trauma/ surgery		Peripheral Oedema	
Hypertension		D.V.T.		Peripheral Neuropathy		Diabetes	
Angina		Cellulitis		Rheumatoid arthritis		Other:	
M.I.		Varicose Veins		Skin Disorder			
C.V.A/T.I.A.		Phlebitis		Malignancy/Cancer			

Other relevant information:

Please complete all sections of this form and fax to: 01274 215660