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| --- | --- |
| Patient Name: | Referrer’s Name: |
| Address: | Job title: |
| Contact tel no: |
| Referral date: |
| Phone no: | Please post referrals to:- Lower Limb Clinic Co-ordinator,St Johns Health CentreLightowler RoadHalifaxHX1 5NB |
| Date of Birth: |
| NHS no: |
| Medical History:- | GP name: |
| Address: |
| Phone no: |
| **REASON FOR REFERRAL**□ Lower limb wound 2 weeks duration . □ Varicose Veins (where the patient Not showing signs of improvement has declined vascular intervention. □ Wound on the lower leg falling outside □ Persistent episodes of varicose eczema or other the field of knowledge of the practitioner. signs of venous hypertension. |
| **WOUND ASSESSMENT COMPLETE: YES/NO** If yes, please forward with referral where possible |
| History of ulceration: |
| Duration of wound | Wound size |
| Location of wound | Tissue type |
| Current management | Exudate |
| Wound pain |
| Other wound related information: |
| Medication (attach list if necessary) | Previous ulceration duration and treatment: |
| Allergies: | Is the patient in compression hosiery? Yes/NoSize: Class: |
|  |
| Relevant medical history contra-indicates compressions therapy eg heart/lung/renal failure:Other relevant information/factors affecting the patient eg nutrition, mobility, concordance, pain:  |
| Is the patient able to attend clinic? Yes No If yes, is transport essential Yes No  |
| (Office use only) Date referral received: | Outcome: |
| Date of 1st Contact: |