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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 Centre  Lightowler Road  Halifax  HX1 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/No  Size: 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: | |