**COMMUNITY**

**NEGATIVE PRESSURE WOUND THERAPY (NPWT) REFERRAL FORM**

**COMPLETE FORM OVERLEAF, AND DISCHARGE TO:**

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| **BRISTOL**,  **SOUTH GLOUCESTERSHIRE**,  OR **NORTH SOMERSET:** | **BATH** AND  **NORTH-EAST SOMERSET:** | **SOMERSET:** | **WILTSHIRE:** |
| **Ring** Single Point of Referral (SPA) line on 0300 125 6789 (TOP TIP for quick response: select option 1 (*HCP*), then option 2 (*secondary care*), then option 1 (*regardless of when visit required*)). They will triage referral out to community nurses | **Ring** to check capacity with District Nurses & TVN  via CCC on 0300 247 0200 | **Ring** to check capacity with  District Nurses on  0300 124 5601 | **Ring** to refer to the District Nursing team on  0300 111 5818  (option 3) |
| **Email** this referral form to:  [sirona.wcs@nhs.net](mailto:sirona.wcs@nhs.net)  (áWound Care Service)  **AND to relevant area SPA:**  [sirch.bristolspa@nhs.net](mailto:sirch.bristolspa@nhs.net) (áBristol)  [sirch.southglosspa@nhs.net](mailto:sirch.southglosspa@nhs.net) (áS.Glos)  [sirch.northsomersetspa@nhs.net](mailto:sirch.northsomersetspa@nhs.net)  (áN.Somerset) | **Email** this referral form to:  [vcl.bathnestissueviability@nhs.net](mailto:vcl.bathnestissueviability@nhs.net)  **AND**  [bathnesccc.referrals@nhs.net](mailto:bathnesccc.referrals@nhs.net) | Email this referral form to:  [TVN@somersetft.nhs.uk](mailto:TVN@somersetft.nhs.uk)  **AND**    [SPAsedgemoor@somersetft.nhs.uk](mailto:SPAsedgemoor@somersetft.nhs.uk) | **Email** this referral form to:  [WHC.tissueviability@nhs.net](mailto:WHC.tissueviability@nhs.net)  Call 01225 711351 with any further enquiries |

**PLEASE ENSURE:**

The patient MUST be sent home with:

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| 2 x NPWT foam packs |  |
| 2 wound bed liners (if applicable) |  |
| 2 x NPWT canisters |  |
| 1 x conventional dressing  Black box for pump and charging lead |  |
| SPA contact number: 0300 125 6789 |  |
| KCI 24-hr helpline: 0800 980 8880 |  |
| Basic information on VAC pump, eg ON/OFF, alarms, etc | |  |

It is preferable **not** to have the first visit arranged on a weekend.

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| Pump Unit ATV No: (must be provided) Click here to enter text. | | |
| Please tick one of the boxes below to confirm who will be providing NPWT management on discharge from acute hospital.  This is to facilitate the community knowing that there is a VAC in the community, even if they are not delivering the NPWT dressing changes. If discharged under NHS@home or an outpatient clinic initially, an updated referral will need to be sent to the community/ district nurse team and Tissue Viability/ Wound Care Service (see details above) if the community/ district nursing team needs to take over the NPWT changes, so they know the current number of foam pieces in the wound, and the wound management plan.   |  |  |  | | --- | --- | --- | | **NHS@home**  Patient will receive NPWT dressing changes by NHS@Home.  Pls also refer patient to NHS@home service. | **Outpatient clinic**  NPWT dressing changes at plastics dressing clinic, burns (hospital based) clinic etc | **Community/ District Nursing Team**  Patient will need NPWT dressing changes by the community/ district nursing team following discharge.  Date of 1st community visit:  DD/MM/YYYY | | | |
| Patient name: | Date of referral: Planned date of discharge: | |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Address:  Click here to enter text. | GP name/ address:  Click here to enter text. | |
| Telephone number for patient: |
| Click here to enter text. |
| Date of birth:  Click here to enter a date. | Referrer:  Click here to enter text. | |
| Ethnicity: | Ward: | |
| Click here to enter text. | Click here to enter text. | |
| NHS number: | Telephone no: | |
| Click here to enter text. | Click here to enter text. | |
| Consultant: | |
| Click here to enter text. | |
| Date of admission to hospital: | Date of admission to current ward: | |
| Click here to enter a date. | Click here to enter a date. | |

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| **Surgical procedure undertaken:** Click here to enter text.  **Any post-operative complications:** Click here to enter text.  **Type and location of wound:** Click here to enter text.  **Date NPWT commenced:** Click here to enter text. |
| **Has the patient been assessed by a Tissue Viability Nurse (TVN) or similar?**  **Yes**   **No** |
| **Measurements of wound at time of referral:**  Please include length, width and depth and undermining measurements.  **Length**:-  **Width**:-  **Depth**:-  **Undermining or tunnelling**:-  **Any additional information** (eg tissue type):- |
|  |
| Details of NPWT dressing currently: Foam  Other |
| How many pieces of foam have been inserted into the wound?: |
| How many pieces of foam have been used to bridge?: |
| Is a liner being used? Yes  No |
| PLEASE NOTE THE PATIENT WILL NOT BE ACCEPTED IF THE AMOUNT OF FOAM USED HAS NOT BEEN RECORDED. |