**Sirona Wound Care Service Referral Form**

**You MUST include recent, clear and identifiable photos, or your referral will be returned and delayed**

**Patients Name:** …………………………………………………………………………….................

**Address:**……………………………………………………………………………………………….…………..………………………………………………………………………..................................

**NHS Number:** ……………………….

**Date of Birth:** ............/............/............

*You can copy & paste all the above details by right clicking on the patients name on Emis and selecting ‘copy details’*

**Referrers Name:** ………………………….......... **Position:** …………………………………............

**Referrers Contact Details: Tele:** ........................................ **Team Email:** ..........................................

**Where are you referring from:** ............................................................................................................

**Please complete all fields below to support our triage assessment:**

**Situation:**

Why are you referring? What would you like us to advise or support you with?

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Background:**

How and when did the wound develop?

……………………………………………………………………………………………………………………………………………………………………………………………………………………

History of dressing regime *(dressing used and frequency)*:

……………………………………………………………………………………………………………………………………………………………………………………………………………………

Significant Past Medical History (including Doppler results if known) and Specialist Involvement:

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Allergies/Sensitives:

……………………………………………………………………………………………………………………………………………………………………………………………………………………

**Assessment:**

|  |  |
| --- | --- |
| Wound location(s) | ………………………………………………………………………………….........  ………………………………………………………………………………….......... |
| Tissue type: | Granulating: ……….%  Sloughy: ……….%  Necrotic: ……….%  Epithelialising: ……….%  Overgranulating: ……….%  Tunnelling/Undermining: ……….%  Other tissue type: ……….% |
| Wound measurements | Length x Width x Depth  …………………………………………….. |
| Infection/  Bacteria: | Please describe concerns/wound swabs/antibiotic therapy:  ………………………………………………………………………………….........  ………………………………………………………………………………….......... |
| Exudate: | Volume: None / Minimal / Low / Medium / High  Viscosity: Serous / Haemoserous / Purulent  Colour: …………………………………… Odour: None / Yes, on dressing removal / Yes, before dressing removal |

**Waterlow Score:** ……………….. **Date last completed:** ............ /............ /............

**SSKIN** (if referring for a pressure injury, please provide information below):

**Skin condition/Pressure injuries** *(details of any skin damage)*:

……………………………………………………………………………………………………………………………………………………………………………………………………........................

**Surface and Equipment** *(details of current pressure reliving equipment in use)*:

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**Keep Moving** *(details of current repositioning regime)*:

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**Incontinence/Skin hygiene** *(details of incontinence status, moisture prevention and hygiene products in use)*:

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**Nutrition, Hydration and MUST** *(details of nutritional intake including any supplements)*:

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**Weight:** ............*kg* **Height:** ............*cm* **BMI:** ............ **Date last completed:** ............/............/............

**MUST Score:** ............ **Date last completed:** ............/............/............