**Tissue Viability – Referral Criteria**

**Mission statement**

**The role of the Specialist Tissue Viability team is to empower nursing and medical staff to provide, competent, evidence based practice in the prevention and management of pressure ulcers, leg ulcers and the management of complex wounds. With the aim of improving practice and ensuring patient safety.**

**Criteria for referral:**

* Patients must be registered with a Berkshire GP or be an inpatient on a Berkshire Healthcare inpatient unit.
* The service will accept patients of all ages.
* Access to the service is via a professional that has already assessed the wound.
* The referral form must be fully complete with all information present, if not it will be returned.
* Patients who are being referred for leg ulceration must have had a full leg ulcer assessment and if appropriate an ABPI (ankle brachial pressure index) performed within the last 12 weeks with sounds documented this must be attached to the referral form.
* The referral will be triaged within 2 days, this may be a telephone call to the refer.

**Services offered by the Tissue Viability team:**

* Assessment of Patients requiring Topical Negative Pressure.
* Assessment of patients requiring larvae therapy.
* Assessment and advice of a wound that is rapidly deteriorating.\*
* Assessment and advice of a wound that is failing to respond to treatment despite appropriate management.\*
* Assessment and advice for uncontrolled symptoms of a wound, e.g. wound pain, exudate management, infection.\*
* Patients with an ABPI (ankle brachial pressure index) between 1.25-1.3
* Patients with normal ABPI but have non-healing ulceration
* Patient’s with an ABPI between 0.8-0.6, where health professionals have concerns and need expert assessment and advice.\*
* Where patients are subject to safeguarding and expert assessment of pressure ulcers is required
* Fungating wounds with uncontrolled symptoms e.g. bleeding, odour.
* Diabetic patient presenting with ulceration, these patients also need urgent referral to the diabetic podiatrist.\*

**\*NB Patients who have been identified as having critical ischemia need direct G.P. referral to vascular consultant.**

**\* Patients with wounds to feet requiring specialist assessment should be referred to Podiatry**

**Berkshire Healthcare TISSUE VIABILITY CLINICAL NURSE SPECIALIST - REFERRAL FORM**

**Email:** [integratedhub@berkshire.nhs.net](mailto:integratedhub@berkshire.nhs.net)

**For wounds below the ankle refer to podiatry**

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| --- | --- |
| **Date of Referral:**  **Patient aware of referral (tick )**  **YES** **NO** | **Referral Source**  **Community Nurse Team:**  **Hospital and Ward Name:**  **Nursing Home Name:**  **Practice nurse:** |
| **Have you discussed this referral with your wound care Nurse, Clinical Lead or link practitioner**  **Yes No**  **Name:**  **Address:**  **Post code:** | **Person completing this form**  **CCG:**  **Name:**  **Email :**  **Referrals**  **Contact number:** |
| **DOB:** | **GP Surgery:** |
| **NHS NO:**   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  | | **Normal days seen (tick as appropriate)**  **Mon Tue Wed Thur Fri** |
| **Practice nurse patients: please add date and times of the next appointments booked.** | |
| **Allergies** | |

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| **Medical History :** |
| **Is the patient known to have :-**  **MRSA Ecoli VRE Cdiff** |

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| **Reason for referral (refer to tissue viability referral criteria)** |
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| --- | --- |
| **Site of wound/s** | **Duration of wound** |
| **Waterlow Score: Date:** | **MUST: Date:** |
| **Pressure Ulcer Category ( please tick)**  **1 2 3 4**  **Developed :**  **Inherited:**  **Where from:** | **Leg Ulcer – Venous / Arterial / Mixed**  **Date:**  **Attach leg ulcer assessment form**  **ABPI**  **Left Leg: Right Leg:**  **Pulse sounds**  **Left Leg Right Leg** |
| **Type of Mattress:**  **Date:** | **Type of Compression Therapy:** |
| **Type of Cushion:**  **Date:** | **Date commenced** |

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| --- | --- | --- | --- | --- |
| **Factors effecting healing: please tick:** | | | | |
| **Diabetes** | **Heart Disease** | **Anaemia** | **Dementia** | **Renal Disease** |
| **Bloods (taken in last 2 months)**  **HbA1c FBC Glucose**  **Other:** | | | | |
| **Is patient choice paper work completed if appropriate:** | | | | |
| **Currently on –**  **Antibiotic:**  **Steroids:** | | | | |
| **Dressing used** | | | | |

**Please attach a current photograph to your referral or upload to RiO**