**T**ISSUE **V**IABILITY **R**EFERRAL **F**ORM

All referrals should be email to:- tissue.vilability@walsallhealthcare.nhs.uk

**Patients name and address: GP Name:**

 **Practice Address:**

**NHS Number: DOB:**

**Referrer Name: Ward**

**Contact Number: Community Base**

**Occupation: Date and time referred**:

BURN

FOR TVN USE:

**Reason for referral**

**Wound location**

**Wound History**

**(Onset and description of wound)**

**Current Wound Management**

**Other professionals involved**

OUTCOME OF VISIT

TVN USE ONLY

OUT COME OF VISIT

TV ONLY

**Pressure Ulcer Category: 1 2 3 4 unstageable DTI**

**Leg ulcer: Venous Arterial mixed unknown**

**Last ABPI reading: LT leg RT leg Last ABPI date:**

**SURGICAL TRAUMA BURN**

**MAGLIGANT/ FUNGATING DIABETIC FOOT ULCER**

 **Other :**

**Recent Past medical History Please state if any risk ( Dogs, MRSA C-DIFF etc)**

 **Wound type:- (please place X in appropriate box)**