COMMUNITY TISSUE VIABILTIY SERVICE REFERRAL FORM.

Guy's and St Thomas' NHS
NHS Foundation Trust

Complete from & email to Gst-tr.TVNReferrals@nhs.net TVN Contact number: 02030498855

PLEASE NOTE THE REFERRAL WILL BE REJECTED UNLESS ALL INFORMATION IS COMPLETED & PHOTO INCLUDED

DATE OF REFERRAL	

PATIENT			
Patient Name:		**DOB**	
		NHS No.	
Address & Postcode			
Telephone No.		**Mobile:**	
GP Name & Address			
Relevant Medical History *Eg Diabetes, COPD, PVD, MS, Immobility, End of Life etc*			

WOUND							
Wound Type: *Highlight and complete box as appropriate*	Pressure ulcer (& Category) Cat:	Moisture lesion	Surgical Dehiscence	Leg Ulcer ABPI Date: Result:	Fungating wound	Skin tear	Other
Location of wound:							
Wound Dimensions:	Length	cm	Width	cm	Depth	cm	Raised?
Wound bed (%):	Necrosis (Black)	%	Slough (yellow)	%	Granulation (Red)	%	Epithelisation (Pink) %
Duration of wound:							
Present wound treatment:							
Days patient visited:							
Reason for referral:							
Wound Photo Required.	Date taken:	**Attached to referral?**	(please tick)	**Uploaded to Carenotes?**	(please tick)		

REFERRER			
Name:		**Designation:**	
Team:		**Locality Base:**	
Referrer Direct Mobile:		**Duty Nurse Mobile:**	
Generic team email:			

TVN Office use only							
Date Received:			**Date referrer contacted:**				
Interim advice given:							
Referral on carenotes		Patient on caseload		Filed where?		Follow up required?	

Please note the Community TVN working hours are Monday to Friday, 9am-4.30pm.
There is no TVN available at weekends or Bank Holidays