Northumberland, Tyne and Wear
NHS Foundation Trust

TISSUE VIABILITY SERVICE REFERRAL FORM

Referred By		Tel No	
Profession		Date	
Has patient given consent for referral		YES	NO

Patient Details

	Patient Name		RIO/NHS Number	
DOB		AGE		
Ethnic Origin		Religion		
Ward/Location			Tel No	
Indicate any identified communication difficulties:			YES	NO
Spoken Language		Interpreter needed	YES	NO
Reason For Referral				

Essential Information

Current problem	Duration of Problem

Relevant Medical History

Please state the tests/investigations/assessments undertaken to date and the results?
Please state the interventions/dressings/treatments currently in place?

Please state other services that are involved? (Podiatry / Vascular etc.)
Please state any supporting information relevant to this referral

Tissue Viability Office Use Only

Referral Received by

Name Date Time

Referral Accepted Referral Not Accepted

(If referral is not accepted , please state rationale)

Referral Signposted to

Date

Referrer Contacted YES NO

Name Date

Appointment Made YES NO

Name Date Time

Related Notes