**Lower Limb Therapy Referral Form**

**Please complete this referral form with a good quality wound photograph and email to:** [**lowerlimbtherapy.referrals@nhs.net**](mailto:lowerlimbtherapy.referrals@nhs.net) **or send to LLTS, Dawlish Hospital, Dawlish, EX7 9DH**

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| --- | --- | --- |
| **Referrer Details** | **Patient Details** | |
| Name: | Name: | DoB: |
| Profession: | Address: | Gender: |
| Address: |
| NHS No.: |
| Patient Consent to this referral?  Yes  No |
| Tel No: | Tel No. (1): | Mobility- Can patient attend clinic:  Yes  No |
| **GP Details** | |
| Email: | GP name**:** | Surgery: |
| Decision to Refer Date: | Tel No: | Surgery e-mail: |

**Please attach additional clinical issues list from your practice system**

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| **Current Medication** |
| **Significant issues, allergies, relevant family history, smoking & alcohol status and morbidities** |

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| **Relevant past medical history** Including a patient clinical summary enables us to triage efficiently  Please advise us of any long term conditions / concordance issues / previous wound infections. |
| **Every new patient will be offered a holistic LU assessment with ABPI/Doppler** |

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| If appropriate date of most recent ABPI | | |  | |
| **Right Leg**  ABPI Result / Pulses |  | | **Left Leg**  ABPI Result / Pulses |  |
| Is the patient in compression bandaging or hosiery? |  | | How long has ulcer been present? |  |
| **Right leg - largest wound details** | | | **Left leg - largest wound details** | |
| Length/width in cm |  | | Length/width in cm |  |
| Depth |  | | Depth |  |
| Location on limb |  | | Location on limb |  |
| **If photos have not been supplied then the above wound details must be completed to enable triage** | | | | |
| Is the patient Diabetic? | No  Insulin dependant  Diet controlled  Tablet | | | |
| Is the patient known to other specialist services? Please indicate as appropriate. | | Vascular  Podiatry  Dermatology Lymphodema  Community Nursing Service  Tissue Viability  Orthopedics  Other (Please specify) | | |