Birmingham Vascular Leg Ulcer Referral Form.

**Inclusion**: Non – healing wound on the lower leg, present for 2 weeks or more.

**Exclusion**: All foot ulcers; Malignancy; Dermatological; Lymphoedema (ref to MHH Lymphoedema team)

|  |  |
| --- | --- |
| **Patient Details**Surname ..............................................................Forename (s) .......................................................Date of Birth ........................................................NHS/Hospital No ................................................Address .........................................................................................................................................................................................................................Postcode .............................................................Contact Number ..................................................Interpreter Required Yes  No Preferred Language ………………………………………… | **Referral**Date of referral ………………………………….……………………………Referrers name ……………………………………………………………….Job Title …………………………………………………………………………..***Referrers DD telephone no*** ………………………………………….….Referring Address ……………………………………………………………**GP Details**GP .......................................................................................Address ......................................................................................................................................................................................................................................................................................................................................................................Contact number ..................................................................Email address …................................................................... |

**Please provide all reasons for referral:** ……………………………………………………………………………………………………………...

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# Wound

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Right Leg** | **Left Leg** | **Comments** |
| Non-Healing Wound*(circle for each leg)* | Yes / No | Yes / No | **If not, please give reason** |
| Duration of Wound*(months / years)* |  |  |
| Compression Therapy | Yes / No | Yes / No |

**Ankle Brachial Pressure Index**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Right** | **Left** | **Comments** |
| Hand Held Doppler (HHD) APBI assessment | Brachial ...........................PT ....................................DP ................................... | Brachial ...........................PT ....................................DP ................................... |  |
| Reading | ......................... | ......................... |

# Mobility Status Photographs

|  |  |  |  |
| --- | --- | --- | --- |
| Fully mobile | Reduced mobility | Mobile with an aid | Immobile |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Has the wound been photographed | Yes / No |  |
| Have they been sent with referral | Yes / No |  |
| Date Taken | Right………………………………. | Left…………………………………. |

**Mental Capacity History of Dementia**: Yes / No If yes: Mild  Moderate  Severe 

**Current wound care treatment** (including compression therapy) ..........................................................……………………

…………………………………………………………………………………………………… **Patients BMI** ………………………………………………….…..

**Past Medical History / Medication** .............................................................…………………………………………………………………

……………………………………………………………………………………………………..……………………………………………………………………………

**Has this patient previously been seen by the Vascular team**: Yes / No If yes which site:………………………………………..