NHS
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

Please Select	**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

Save the Form

Print The Form

Email to Tissue Viability