**North Manchester Lower Limb Specialist Services Referral**

**Patient Name:** **NHS No: DOB:
Patient Address:**

**Referral: URGENT NON-URGENT**

**Specialist service(s) referred to:** Tissue ViabilityHigh Risk Foot Home IV Therapy

Leg Ulcer Lymphoedema Leg Circulation (suspected PAD)

**Referral reason:** Foot / leg wound (> 2 weeks) Foot / leg infection (> 2 weeks) Venous skin changes

 Foot / leg oedema (> 3 months) Intermittent claudication Non-palpable / monophasic foot pulses

Rationale for referral:

Allergies & relevant medical history:

Investigations & current treatment plan initiated by referrer:

Patient understanding of need to have specialist lower assessment has been agreed? Yes No

|  |  |  |
| --- | --- | --- |
| **Foot Pulses** | **Right** | **Left** |
| Palpable Yes **No** | Doppler Tri Bi **Mono** | Pressure mmHg | Palpable Yes **No** | Doppler Tri Bi **Mono** | Pressure mmHg |
| Posterior tibial  |  |  |  |  |  |  |
| Anterior tibial |  |  |  |  |  |  |
| Brachial or radial |  |  |  |  |  |  |
| ABPI | Right: | Left: |

 

Mark wound or symptom locations on the diagram

 Has your patient seen a specialist lower limb service before? Yes No

Has access to patient Graphnet / EMIS been prior agreed? Yes No

Can the patient transfer to a treatment couch? Yes No

Is a bariatric treatment couch essential? Yes No

Have relevant investigations been initiated by the referrer? Yes No

**Details:**

Is an interpreter needed? Yes No Language:

**Additional comments:**

**Referred by:** **Role: Date: Base:**

**Email address of referrer**:**Referrer phone number:**