

**Crawley CCG and Horsham and Mid Sussex CCG**  
**REFERRAL FORM - Any Qualified Provider (AQP) Leg Ulcer Service**



Patient details (only patients over 18)		GP/Referrer details	
Surname:		Dr:	CCG: Crawley <input type="checkbox"/> Horsham & Mid Sussex <input type="checkbox"/>
First Name:		Practice name:	Practice Code:
Age/D.O.B.:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Address:	
Address:	Patient NHS Number:		
Postcode:		Postcode:	
Tel (home):	Tel (work):	Tel number for urgent findings:	
Tel (mobile):	Email:	nhs.net email (for patient update information to be sent):	
Communication difficulties (specify if any)		Fax:	
Will the patient be attending with or require an interpreter? <input type="checkbox"/>			
<b><i>The patient must be ambulant, or if a wheelchair user, they must be able to transfer independently</i></b>		Wheelchair user: <input type="checkbox"/> Yes Other physical difficulties:	
WOUND DETAILS			
<b>Type of wound:</b> VLU <input type="checkbox"/> Arterial <input type="checkbox"/> Mixed LU <input type="checkbox"/> Pilonidal <input type="checkbox"/> Non healing surgical >4 weeks <input type="checkbox"/> Chronic oedema <input type="checkbox"/> Other <input type="checkbox"/> (If other please state type of wound here):		<b>Date of onset:</b>  <b>Location of wound:</b>  <b>Healing status:</b> Healing <input type="checkbox"/> Deteriorating <input type="checkbox"/> Static >6 weeks <input type="checkbox"/> >12 weeks <input type="checkbox"/>	
<b>Nutrition:</b> MUST Score:                      Diet: Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/> Supplements Yes <input type="checkbox"/> No <input type="checkbox"/> <b>BMI:</b>			
<b>Exudate:</b> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Colour:			
<b>Current wound treatment:</b>   			
<b>Wound infection:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes state infection present (if known):			
<b>Wound swab taken:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Antibiotics commenced/requested: Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Other symptoms:</b> Cellulitis <input type="checkbox"/> Increased exudate <input type="checkbox"/> Pain <input type="checkbox"/> Malodour <input type="checkbox"/> Pyrexia <input type="checkbox"/> Other <input type="checkbox"/> (please state)			

<b>Wound bed condition:</b> (show %)			
Healthy granulation (red)	Necrosis (black)	Hypergranulation (raised)	
Slough (yellow/grey)	Other (please state)		
<b>Wound dimensions:</b> (cms)		<b>Pain:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Score (0-10):	
Max length	Max width	Max depth	
<b>Undermining/tunnelling:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Analgesia</b> (type):	
<b>Peri wound skin</b> (tick all that apply):			
healthy <input type="checkbox"/> haematoma <input type="checkbox"/> oedema <input type="checkbox"/>			
excoriation <input type="checkbox"/> moist/maceration <input type="checkbox"/>			
dry/flaky <input type="checkbox"/> dermatitis/eczema <input type="checkbox"/> other <input type="checkbox"/>			
<b>MEDICAL HISTORY</b>			
Diabetes <input type="checkbox"/> Peripheral arterial disease <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Malignancy/end of life <input type="checkbox"/>			
Medications: Steroids <input type="checkbox"/> Warfarin <input type="checkbox"/> Insulin <input type="checkbox"/> NSAIDs <input type="checkbox"/> Diuretics <input type="checkbox"/> Tramadol <input type="checkbox"/> Anti hypertensives <input type="checkbox"/> please list any others (including antibiotic therapy)			
Comments:			
Signature:		Name:	Date:
<b>SELECT PROVIDER</b>			
<b>Healogics Wound Healing Centres CIC – includes VLU, arterial and mixed LU</b>		<b>Sussex Community NHS Trust – includes VLU, arterial or mixed LU</b>	
Saxonbrook Medical, Northgate, <b>Crawley</b> (Mon/Tues/Wed/Thurs/Fri) Tel: 01293 450400	<input type="checkbox"/>	Crawley Hospital, <b>Crawley</b> (Mon/Wed/Thurs) Tel: 01293 228311 or fax: 01293 600399	<input type="checkbox"/>
Moatfield Practice <b>East Grinstead</b> (Mon/ Thurs) Tel: 01293 223028 or fax: 01403 261402	<input type="checkbox"/>	Health Clinic, <b>East Grinstead</b> (Tues/Thurs) Tel: 01293 228311 or fax: 01293 600399	<input type="checkbox"/>
Unit 7, City Business Centre Hospital, 6 Brighton Road, <b>Horsham</b> , RH13 5BB (Mon/Tues/Wed/Thurs/Fri) Tel: 01403 334332 or fax: 01403 261402	<input type="checkbox"/>	Health Centre, <b>Haywards Heath</b> (Fri) Tel: 01293 228311 or fax: 01293 600399	<input type="checkbox"/>
Avenue Surgery, <b>Burgess Hill</b> (Mon/Tues/Wed/Thurs) Tel: 01444 220549 or fax: 01403 261402	<input type="checkbox"/>	Hassocks Health Centre, <b>Mid Sussex</b> (Wed/Thurs) Tel: 01293 228311 or fax: 01293 600399	<input type="checkbox"/>
The Vale Practice, <b>Haywards Heath</b> (Mon/Tues/Thurs/Fri) Tel: 01444 220549 or fax: 01403 261402	<input type="checkbox"/>	Horsham Hospital, <b>Horsham</b> (Tues/Thurs) Tel: 01293 228311 or fax: 01293 600399	<input type="checkbox"/>
	<input type="checkbox"/>		
For this provider: If you are a practice in Horsham and Mid Sussex CCG please email your request to <a href="mailto:WSXCCG.HORSHAM-MIDSUSSEX-CCGREFERRALSWHC@NHS.NET">WSXCCG.HORSHAM-MIDSUSSEX-CCGREFERRALSWHC@NHS.NET</a> If you are a practice in Crawley CCG please email your request to <a href="mailto:WSXCCG.CRAWLEY-CCG-REFERRALSWHC@NHS.NET">WSXCCG.CRAWLEY-CCG-REFERRALSWHC@NHS.NET</a>		All requests should be emailed to <a href="mailto:SC-TR.OneCall-North-ReferralsOnly@nhs.net">SC-TR.OneCall-North-ReferralsOnly@nhs.net</a> for this provider	