Birmingham Community Healthcare **NHS**
NHS Trust

West Heath Hospital
Specialist Leg Ulcer Clinic referral form

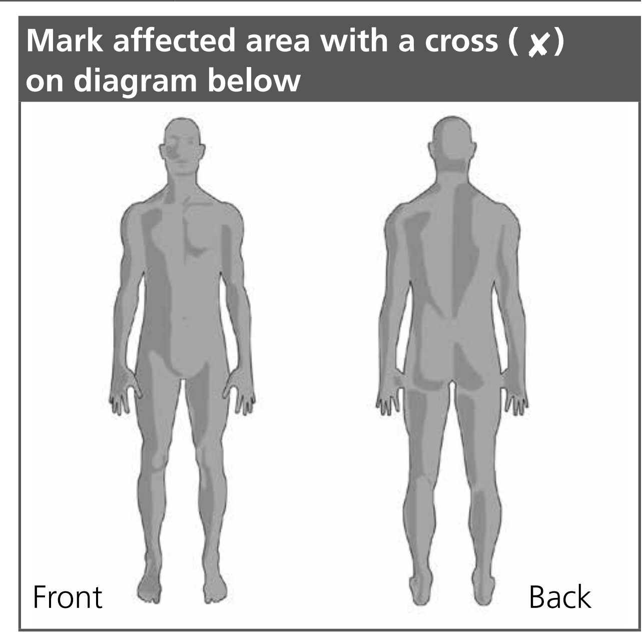
All referrals must be faxed or sent by post to:
St Stephens Centre, 171 Nineveh Road, Handsworth, Birmingham B21 0SY • Fax: 0121 466 3621

Please complete all sections fully. Omitted sections may delay the allocation of an appointment.

Patient details	NHS number:	
Surname:	First name:	Preferred name:
Date of birth:	Age:	Gender:
Marital / civil status:	Religion:	Ethnicity:
Address:		Post code:
Tel home:	Tel work:	Mobile:
Preferred first language:	Communication support required: YES / NO (please circle)	Interpreter required: YES / NO (please circle)
Other communication barriers, e.g. hearing loss, visual impairment:		
Patient aware of referral YES (please tick ✔) Please refer to BCHC Consent Policy.		
GP details	Name:	Tel:
Address:		Post code:
Consultant details	Name:	Tel: Fax:
Address:		Post code:

Reason for referral (please circle)		Duration of symptom
Ulceration	YES / NO	
Recurrence of an ulcer	YES / NO	
Non healing/static leg wound	YES / NO	
Deteriorating leg wound	YES / NO	
Chronic infection	YES / NO	
Painful legs	YES / NO	
Varicose veins	YES / NO	
Irritated dry skin to the legs	YES / NO	
Staining to the limbs	YES / NO	
Other (please specify):		

Mark affected area with a cross (✘) on diagram below



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Patient name:	
NHS number:	

Medical history

Please attach a patient summary in addition to any relevant correspondence, investigations, blood results, interventions, current treatment, when the patient was first referred to your service:

Medication

Risk management concerns - are there any safety or security issues involved in seeing this patient?

BMI (If BMI greater than 35 then please refer to BCHC Specialist Obesity Service):

Alerts (MRSA / tissue viability / manual handling concerns):

Allergies (drug allergies / skin sensitivities / latex allergies):

Other:

Multi-disciplinary services involved

District nurse:	Other:
Name:	Name:
Team:	Team:
Address: Post code:	Address: Post code:
Telephone:	Telephone:

Additional comments:

Referrer details:

Name (print):

Sign:

Designation:

Date:

Team / service / practice:

Address:

Post code:

Telephone number:

Mobile:

Email:

Official use:

Priority:

Clinic appointment offered?: YES / NO

Comments:

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