

Discharge Communication Form B for Patients Requiring Wound Care



Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Please confirm the service the patient requires:	
District nurse (house bound patient)	
Tier 3 Hub/GP	
Skin Integrity Complex Wound Clinic at DBTH	
Tissue Viability and Lymphoedema Service (TVALS) at RDaSH	

Forename (s):	Last Name:
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NHS Number:	Gender:	Date of Birth:
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Address (to include postcode):	Name of GP and GP Address:
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Patient contact (Home):	GP Surgery Contact number:
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Patient contact (Mobile):	Name of Consultant/Specialist:
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Date of preferred visit:	NOK details:
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Medical History:

Medications:	Allergies:
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Wound management	Negative Pressure Wound Therapy
Lower Limb assessment	Lymphoedema (non cancer related)
(+/- Doppler/ABPI/TBPI)	Lymphoedema (cancer related)
Equipment	Removal of Clips / Suture
Larval Therapy	

Section A - Please complete for wounds healing by Primary (e.g. surgical wound)

Date and Time of wound closure	Location of incision
Date for removal of clips	Date for removal of drain(s)
Dressing used	Date of first dressing change
Type of wound closure	Skin closure used

Section B - Please complete for wounds healing by Secondary Closure (e.g. pressure ulcer, leg ulcer)

		Site 1	Site 2
Location:			
Wound Type:			
Wound Duration:			
Tissue	Epithelialisation (%):		
	Granulation (%):		
	Slough (%):		
	Necrotic (%):		
	Other, please state: e.g. DTI/ Supporting Structures/Eschar		

Infection	Odour:	<input type="checkbox"/> Offensive <input type="checkbox"/> Some <input type="checkbox"/> None	<input type="checkbox"/> Offensive <input type="checkbox"/> Some <input type="checkbox"/> None
	Infection suspected:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Wound swab sent:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Antibiotics prescribed:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Moisture	Amount:	<input type="checkbox"/> None	<input type="checkbox"/> None
		<input type="checkbox"/> Minimal	<input type="checkbox"/> Minimal
		<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate
		<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy
	Type:	<input type="checkbox"/> Serous	<input type="checkbox"/> Serous
		<input type="checkbox"/> Haemoserous	<input type="checkbox"/> Haemoserous
		<input type="checkbox"/> Purulent	<input type="checkbox"/> Purulent
		<input type="checkbox"/> Haempurulent	<input type="checkbox"/> Haempurulent
Edge	Max. width (cm):		
	Max. length (cm):		
	Max. depth (cm):		
Surrounding Skin	Healthy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hyperhydration:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Maceration:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dry:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Rolled Edges:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Oedema present:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other, please state:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Dressings for discharge	Site 1	Site 2
Preventative care:		
Wound cleansing:		
Peri wound care:		
Primary dressing:		
Secondary dressing:		
Bandages in order of app:		
NPWT:		
NPWT Settings:		
Wound Contact Layer:		
Wound Foam/Gauze:		
NPWT:		
Comments:		
Name of completed RGN/NA:	Date and Time:	Discharging Ward/Department:

Please ensure a 3 day supply of dressings and products are provided to the patient on discharge.