Vascular Service - Venous Insufficiency Referral Form

Patient Details

Name:		**NHS number:**	
Address:		**Date of Birth:**	
		GP details:	
		Patient contact number:	
Post Code:		**Date of referral:**	
Can the patient attend an outpatient department?	**Yes** ☐ **No** ☐	**Transport required?**	**Yes** ☐ **No** ☐

Past Medical History: *(Including smoking history) (Patients GP history from sysym one can be attached).*

Medication: *(Patients GP history from sysym one can be attached).*

Allergies:

Screening questions and reason for referral

1	Clinical evidence of **severe infection / sepsis** with systemic signs eg. tachycardia, pyrexia, hypotension, or patient feeling unwell, or spreading cellulitis, crepitus or significant deterioration over a short period of time.	**Yes**	☐	**No**	☐
	If you answered Yes to Question 1 the patient requires an EMERGENCY admission				
2	If there is suspected acute deep vein thrombosis or superficial vein thrombosis.	**Yes**	☐	**No**	☐
	If you answered Yes to Question 2 the patient requires a referral to the local DVT service				
3	Are there signs of suspect peripheral arterial disease.	**Yes**	☐	**No**	☐
	If you answered Yes to Question 3 STOP and use the Peripheral Arterial Disease / Chronic Limb Threatening Ischemia Referral Form				
4	Does the patient have any risk factors or visual signs for venous disease on the lower limb including ulceration? (a break in the skin below the knee that has not healed within 2 weeks).	**Yes**	☐	**No**	☐
5	Does the patient have a static or deteriorating venous leg ulcer despite optimum compression therapy?	**Yes**	☐	**No**	☐
6	Has the patient had acute venous bleeding from the leg requiring first aid treatment?		☐		☐
	If you answered yes to Question 4 and either 5 or 6 the patient requires an URGENT referral to the Vascular Service				

Essential information

Already known to the Vascular Service? **Yes** ☐ **No** ☐

History of the following		**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
	DVT	☐	☐	Fixed or restricted ankle movement	☐	☐	Leg fracture / replacement joints	☐	☐
	Oral contraceptive/ HRT	☐	☐	Previous varicose vein surgery	☐	☐	History of superficial vein thrombosis	☐	☐

Signs of venous disease (CEAP)	**Left**		**Signs of venous disease (CEAP)**	**Right**	
	Yes	**No**		**Yes**	**No**
Ache, pain, tightness, itch, heaviness	☐	☐	Pigmentation or eczema	☐	☐
Telangiectasia or reticular veins	☐	☐	Lipodermatosclerosis or atrophie blanche	☐	☐
Varicose veins	☐	☐	Ankle Flare	☐	☐
Oedema	☐	☐	Healed Ulcer	☐	☐
Changes to skin and subcutaneous tissues	☐	☐	Active Ulcer	☐	☐

Additional Information. Do not delay referral if this section cannot be completed.

ABPI reading	**Left:**		**Right:**	
Posterior tibial pulse palpation /waveform/signal	**Left:**		**Right:**	
Dorsalis pedis pulse palpation/ waveform/signal	**Left:**		**Right:**	

Is a photography available and been sent with this referrals for? **Yes** ☐ **No** ☐

Any additional Information:

Referrer details

Name:		Department/service:	
Role:		Contact details:	
Date:		Time:	

National Wound Care Strategy Programme

Send to dbth.vascular-admin@nhs.net

VASCULAR SOCIETY