

**Leg Ulcer Pathway Referral Form**

***Instructions:***Please enter the appropriate information in each field listed below.

**Email the completed form to** gst-tr.vascular-referrals@nhs.net

* **Inclusion**: Non-healing lower limb leg ulcer >2 weeks
* **Exclusion**: Diabetic Foot Ulcer, Pressure Ulcer, Malignancy, Dermatological and

 Autoimmune Conditions.

* If patient needs to be seen within 72hrs, refer to Emergency Vascular Clinic http://slcn.nhs.uk/sevn/leg-ulcers/
* **If patient needs to be seen within 24hrs, refer to A&E**

**Patient Information:**

|  |
| --- |
| Patient Name:  |
| Date of Birth (DD/MM/YYYY):  |
| NHS ID number or GSTT hospital Number:  |
| Address: |
| Patient contact Number: |
| Allergies: |

**Referrer Information:**

|  |
| --- |
| Referrer Name:  |
| Clinic/Surgery/Practice Name: |
| Date of Referral (DD/MM/YYYY): |
| GP Phone Number/email: |
| Address: |

**Ulcer Information:**

Does the patient have a non-healing lower limb ulcer > 2 weeks? [ ] Yes [ ]  No [ ]  Unsure

Amount of time with current active ulcer: (months/years)

ABPI taken? [ ] Yes [ ]  No [ ]  Unsure / Unknown --- If No or Unsure/Unknown, please state reason why:

ABPI measurement (if known):

Presence of recurrent leg varicose veins? [ ] Yes [ ]  No [ ]  Unsure / Unknown

History of Deep Vein Thrombosis? [ ] Yes [ ]  No [ ]  Unsure / Unknown

Current Wound Care Therapy:

**Notes / Comorbidities:**

**(**Alternatively attach GP summary of care record**)**