Tissue Viability Nurse (TVN) Referral Form For Nursing Home Residents

FRESENIUS KABI

Resident name	
Resident date of birth	
Nursing Home name and address	
Name of referrer and job title	
Date of referral	
Contact telephone number	
Contact email address	

Consent
Please select as appropriate:

- The resident has consented to this referral ☐
- The referral has been made in the resident's best interests ☐

Please note that only referrals which comply with one of more of the following are appropriate and will be accepted:

- An open wound present for greater than 2 weeks
- Pressure ulcer grade 3 and above
- Continence lesion which is not responding to use of barrier products
- Leg ulcers that are present for greater than 4 weeks with no improvement

Type & location of Wound on body Stage of pressure ulcer if applicable		
Size of the wound (cm)	Length _____ cm Breath _____ cm Depth _____ cm	
Description of wound exudate	Exudate Type ☐ Serous – Clear Fluid ☐ Sanguineous - Bloody Fluid ☐ Serosanguineous – Clear Blood-tinged Fluid ☐ Purulent – Yellow Thick Fluid	Amount of Exudate ☐ Small ☐ Moderate ☐ High
Medical history relevant to wound		

Fresenius Kabi Ltd
Unit 3B Fingal Bay, Balbriggan, Co. Dublin, Ireland
www.fresenius-kabi.ie
IE-FK-NPR-2400151. Date of Preparation: November 2024

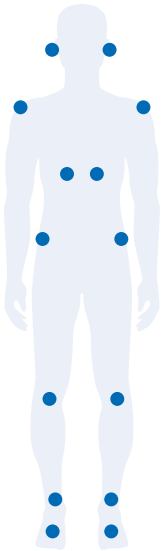
Continence status	
Nutritional status (Weight/BMI/MUST score)	
Dressings used in past	
Dressings currently in use	
Last TVN review date and name of nurse (if applicable)	

Smoker ☐

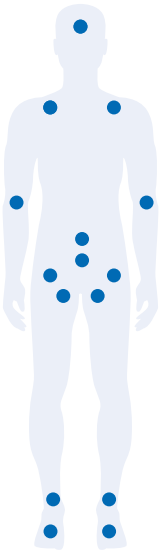
Non-smoker ☐

Mark on the body map where the wound is located →

FRONT



BACK



Please attach photographs of wound
(Include body location, patient ID and date taken on a label within photograph)

Please read the following carefully, before signing to confirm your understanding and returning the form:

- The resident (or referrer if the resident is unable to give informed consent) understands that the personal information will be securely used, stored and shared in order to provide ongoing clinical care.
- The information obtained by this form will be used for the purposes of therapeutic assessment only by an independent TVN engaged by Fresenius Kabi and will not be used for any other purpose or by any other party. For more information on how we use this data please click here.
- Incomplete referrals will be returned and may delay the referral to treatment time.

Referrer name: Date:

Please review the form before signing.

Save this form and send it to: TVNreferrals@fresenius-kabi.ie

The referral will be triaged and passed on to an independent TVN who will contact you to discuss the next steps.