**CTAC EDINBURGH REFERRAL FORM **

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| **FULL NAME:** **DOB/CHI:****CONTACT NUMBER:****ADDRESS:** |
| **DOPPLER****REASON FOR REFERRAL****DOES THE PATIENT REQUIRE A HOSIERY REVIEW:****Does the patient have ulcers or lower leg wound:** **HAS PATIENT HAD A DOPPLER IN LAST 6 MONTH****IS THIS AN URGENT REFERRAL:**  | **WOUND CARE****REASON FOR REFERRAL****WOUND HISTORY:****FREQUENCY AND LIST OF CURRENT DRESSINGS****Frequency:** **List of current dressings:**\*Patients are offered an appointments with CTAC within 72hours. |
| **DOES THE PATIENT REQUIRE****BARIATRIC BED WHEELCHAIR ACCESS TRANSLATION**☐ ☐ ☐ |
| **REFERRAL BY:** **Email:****Tel:** |

Please note that CTAC appointments are booked across multiple Edinburgh sites. We will make every effort to allocate patients to their nearest clinics, however they might be asked to travel. Saturday and Sunday clinic is run in Sighthill.

**Email the completed referral form to:**

**loth.ctacedinburgh@nhs.scot**