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| **NAME:**    **DOB/CHI:**  **ADDRESS:**  **CONTACT NUMBER:** |
| **REASON FOR REFERRAL:**  **IF REFERRAL IS FOR DOPPLER DOES THE PATIENT HAVE ULCERS OR LOWER LEG WOUND?** |
| **RELEVANT PAST MEDICAL HISTORY:**  **REVELANT ALLERGIES:** |
| **WOUND HISTORY:**  **HAS PATIENT HAD A DOPPLER IN LAST 6 MONTHS? No**  **IF YES PLEASE LIST PREVIOUS RESULT:** |
| **FREQUENCY OF AND LIST CURRENT DRESSINGS USED:**  **Date CTAC to take over care from (MUST BE MINIMUM 1 WEEK FROM REFERRAL):** |
| **IF DOPPLER ONLY PLEASE PROVIDE BRIEF CLINICAL REASON FOR REFERRAL:** |
| **REFERRAL BY** |

**Send referrals to loth.ctacedinburgh@nhslothian.scot.nhs.uk**