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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**