Oxford Health NHS
NHS Foundation Trust

TISSUE VIABILITY EQUIPMENT REQUEST FORM

For the provision of beds, mattresses, cushions and specialist chairs.

Please print clearly as inability to read form will result in delay.

All fields must be completed, any incomplete forms will be returned.

Please make sure you include a **mobile** telephone number which you will be available on in case Tissue viability needs to contact you.

SUBMIT via email to:

tissueviabilityADMIN@oxfordhealth.nhs.uk
or
oxfordhealth.tissueviability@nhs.net (if you do not have an oxford health account),
or
FAX to Tissue Viability @ 01865 261757

It is safer to email your referral in. You will also get an automated confirmation of receipt.

If you urgently need to contact someone about your order, please ring Tissue viability admin on 01865 904271/904959.

For assistance in assessing for the appropriate equipment, please refer to the following documents:

- Pressure redistributing equipment: a guide for community clinicians
- Mattress selection guide
- Cushion selection guide
- Criteria for the supply of riser recliner chairs
- Criteria for the supply of hospital beds into residential care homes
- Guide to Heel Protectors
- Frequently requested information on pressure relieving equipment

These are also available on the equipment tab of the tissue viability website in the INTERnet at:
www.oxfordhealth.nhs.uk/tissue-viability

EQUIPMENT ON LOAN: Have you informed the client that this is NHS/ICES equipment on loan and they are responsible for it while it is their possession? Any neglect, damage or disposal may incur a claim from the PCT.

EQUIPMENT COLLECTION: Please note: Equipment collection will not be before 5 days after request of collection. Please make client or family aware when discussing provision.

NHS Number	
Patient Name	

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Date of Birth	
Telephone Number (including area code)	
Mobile Number	
Address	
Postcode	
Medical History	
Height	
Weight	

Delivery speed is normally 5 working days. If an earlier delivery is required, please indicate timeframe (same day, next day, 2 days, 3 days) and a reason for request:	Delivery timeframe requested: SAME DAY ☐ NEXT DAY ☐ 2 DAYS ☐ 3 DAYS ☐ 5 DAYS ☐
If a timed delivery is necessary please provide details:	
DELIVERY INSTRUCTIONS	
Person to contact for delivery Contact number Any special instructions	
PRESCRIBER	
Name of Assessor/Prescriber	DATE:
Team	
Designation	
Preferred Telephone Number (ideally a mobile)	
Email	

NHS Number	
Patient Name	

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TISSUE VIABILITY INFORMATION

Current Pressure Ulcer	Yes ☐	No ☐	Grade of damage (EPUAP)	**1** ☐	**2** ☐	**3** ☐	**4** ☐
Previous pressure ulcer	Yes ☐	No ☐	Grade of damage (EPUAP)	**1** ☐	**2** ☐	**3** ☐	**4** ☐

Please specify location of all present or previous pressure damage	

Risk of developing pressure damage	**Not at Risk** ☐	**Low Risk** ☐	**Medium Risk** ☐	**High Risk** ☐

MOBILITY

Immobile	Hoisted	Transfer with help	Self-transfer
☐	☐	☐	☐

Walks unaided	Walking with equipment	Wheelchair dependant
☐	☐	☐

POSITIONING IN BED

Back	Side to Side	Semi - Reclined	Sitting	Turning routine in place
☐	☐	☐	☐	☐

Are they independent in moving own position? **Yes** ☐ **No** ☐

Is there help available to reposition patient? **Yes** ☐ **No** ☐

Time in bed (Hours)	**Night only** (Hours)	**Rest during day** (Hours)
Time in chair (Hours)	**Night only** (Hours)	**Day** (Hours)

Is the current bed a: **single** ☐ **double** ☐

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Equipment to be requested

BED REQUEST

Profiling Bed ☐	Bedrails with foam in fills ☐

If 4 section bed required please state why:

MATTRESS

A patient's own single bed can have a dynamic pressure mattress on it, as long as the mattress fits the bed base. You cannot put a single dynamic mattress on a double bed.

Foam Replacement / Base Mattress	Foam Single Topper	Foam Double Topper
☐	☐	☐

Repose Mattress Topper	Premier Active (combination) replacement mattress	Full dynamic replacement mattress
☐	☐	☐

CUSHION

Measure the seat base width and depth; make sure that the cushion does not affect the patient's posture or positioning.

Basic foam Essentials	Repose	Foam & gel Flowform Ultra90	Roho	Starlock
☐	☐	☐	☐	☐

FOOT PROTECTORS

Repose boots (pair) ☐

Heel Lift Boot (single) ☐	Petite ☐	Standard ☐	Bariatric ☐
Reason for heel lift boot request:			

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SEATING REQUEST

If you require a riser recliner chair as part of an active management plan for lympho-venous disease please refer to the criteria for supply of riser recliner chair and provide further information below:

Is equipment required to facilitate hospital discharge from the acute sector? **Yes** ☐ **No** ☐

Planned date of discharge	
Discharge from (ward/hospital)	

Awaiting Care Package?	**Yes** ☐	**No** ☐

Details of planned care package:

Reason for request and further information (e.g. seating measurements).

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RISK ASSESSMENT:

Please note this additional page will be sent to Millbrook by Tissue Viability/ASSESSOR, any missing information may result in a delay in delivery or a non delivery. Please complete fully.

OXFORDSHIRE COUNTY COUNCIL
SOCIAL & COMMUNITY SERVICES
www.oxfordshire.gov.uk

Confidential Information

RISK ASSESSMENT ACCESS FORM
USED IN ALL CASES FOR THE PROVISION of BEDS, RISER RECLINER CHAIRS AND HOISTS
All fields must be completed, any incomplete forms will be returned.
Please print clearly as inability to read form will result in delay. NB form electronically available on Millbrook site and best sent this way

DATE:	
CLIENTS NAME:	
ADDRESS:	

Request for: Please Tick √	Bed	Chair	Hoist
Standard (catalogue stock item)			
Special order			
New Provision			
Replacement/repair			

Please attach a quote if special order

Environmental/Access Assessment

2	Bungalow	☐	House	☐	Flat	☐	Cottage	☐	Terrace	☐	Care Home	☐	Warden	☐

3. Stair Lift	Yes ☐	No ☐	**4. Ramps**	Yes ☐	No ☐	**5. Delivery**	Upstairs ☐	Downstairs ☐

6. Steps to:	Front door ☐	Back door ☐	Inside ☐	Outside ☐	None ☐
7. Parking:	Off Road ☐	Own Drive ☐	Road side ☐	Permit only ☐	

8. Other considerations: e.g. pets, infectious diseases, lack of space, obstacles, sanitation:

Yes ☐ **No** ☐

If yes please advise

Risk Assessment for Delivery:

NB. Where possible family/friends must be responsible for moving any furniture. Furniture moved by the delivery men will not be covered on the house insurance. All furniture must be moved PRIOR to delivery. If the company is required to move furniture prior notice must be given and will incur further costs.

Has the client given their consent for this equipment	**Yes** ☐	**No** ☐	**If yes please explain:**
Does the delivery need to be co-ordinated with carers	**Yes** ☐	**No** ☐	
Will the delivery men need to move furniture	**Yes** ☐	**No** ☐	

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FOR TISSUE VIABILITY OFFICE USE ONLY

Date order received:

Roho/ Starlock ordered: Yes ☐ No ☐			Contacted prescriber re set up date: Yes ☐ No ☐
Prescriber able to set up Roho/ Starlock: Yes ☐ No ☐			contact details of rep given to:
Comments re Roho/ Starlock order:			
Messages Left	Date	TV Nurse	Questions to be asked
Call One			
Call Two			
Call Three			

Equipment authorised (YES):

Delivery timeframe authorised:

SAME DAY	☐	2 DAYS	☐	5 DAYS	☐
NEXT DAY	☐	3 DAYS	☐		

Equipment not authorised (NO):

Rational for Decision:

Authorising Signature: Date:

Complex equipment progression

Date	Issue	Action	What next