

TISSUE VIABILITY EQUIPMENT REQUEST FORM

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

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

We no longer receive FAXES so please SUBMIT via email to:

tissueviabilityADMIN@oxfordhealth.nhs.uk
(if you do not have an oxford health account),

You will 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 which are available on the Equipment tab on our website www.oxfordhealth.nhs.uk/tissue-viability

- Pressure Relieving Equipment Formulary: A guide for clinicians
- Mattress selection guide
- Cushion selection guide
- Guide for use of heel protectors
- Criteria for the supply of riser recliner chairs
- Criteria for the supply of hospital beds into residential care homes
- Frequently requested information on pressure relieving equipment

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 the request of collection. Please make client or family aware when discussing provision.

NHS Number	
Patient Name	

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

<p>Delivery speed is normally <u>5 working days</u>. If an earlier delivery is required, please indicate timeframe (same day, next day, 2 days, 3 days) and a reason for request:</p>	<p>Delivery timeframe requested:</p> <p>SAME DAY <input type="checkbox"/></p> <p>NEXT DAY <input type="checkbox"/></p> <p>2 DAYS <input type="checkbox"/></p> <p>3 DAYS <input type="checkbox"/></p> <p>5 DAYS <input type="checkbox"/></p>

If a timed delivery is necessary please provide details:

DELIVERY INSTRUCTIONS

Person to contact for the delivery Contact number Any special instructions	
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PRESCRIBER

Name of Assessor/Prescriber	DATE:
Team	
Designation	
Preferred Telephone Number (ideally a mobile)	
Email	

NHS Number	
Patient Name	

TISSUE VIABILITY INFORMATION

Current Pressure Ulcer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Grade of damage (EPUAP)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Previous pressure ulcer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Grade of damage (EPUAP)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Please specify the location of all present or previous pressure damage	
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Risk of developing pressure damage	Not at Risk <input type="checkbox"/>	Low Risk <input type="checkbox"/>	Medium Risk <input type="checkbox"/>	High Risk <input type="checkbox"/>
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MOBILITY

Immobile <input type="checkbox"/>	Hoisted <input type="checkbox"/>	Transfer with help <input type="checkbox"/>	Self-transfer <input type="checkbox"/>
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Walks unaided <input type="checkbox"/>	Walking with equipment <input type="checkbox"/>	Wheelchair dependent <input type="checkbox"/>
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POSITIONING IN BED

Back <input type="checkbox"/>	Side to Side <input type="checkbox"/>	Semi - Reclined <input type="checkbox"/>	Sitting <input type="checkbox"/>	Turning routine in place <input type="checkbox"/>
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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 the day (Hours)
Time in chair (Hours)	Night only (Hours)	Day (Hours)

Is the current bed a: single double

NHS Number	
Patient Name	

Equipment to be requested

BED REQUEST

If ordering bedrails you MUST complete a Bedrails Risk assessment

Profiling Bed <input type="checkbox"/>	Bedrails with foam infills <input type="checkbox"/>
	Have you completed a Bedrails Risk Assessment? <input type="checkbox"/>

WE WILL NOT ORDER BED RAILS UNLESS A RISK ASSESSMENT HAS BEEN COMPLETED

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 <input type="checkbox"/>	Foam Single Topper <input type="checkbox"/>	Repose Mattress Topper <input type="checkbox"/>
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ROHO Mattress Topper <input type="checkbox"/> <small>NB clinician will need to set this up and order a base mattress</small>	Premier Active (combination) replacement mattress <input type="checkbox"/>	Full dynamic replacement mattress <input type="checkbox"/>
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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 <input type="checkbox"/>	Repose <input type="checkbox"/>	Foam & gel Flowform Ultra90 <input type="checkbox"/>	Roho <input type="checkbox"/>	Vicair Vector 02 <input type="checkbox"/>	Starlock <input type="checkbox"/>
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FOOT PROTECTORS

Repose boots (pair)

SAFETY ALERT – does the patient have a cardiac pacemaker? YES NO

The repose foot protector PLUS with magnetic straps is not suitable for those with pacemakers. The standard Repose foot protectors should be used in this instance.

Heel Lift Boot (single) <input type="checkbox"/>	Petite <input type="checkbox"/>	Standard <input type="checkbox"/>	Bariatric <input type="checkbox"/>
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Reason for heel lift boot request:

NHS Number	
Patient Name	

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 the supply of riser recliner chair on our website and provide further information below:

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

Planned date of discharge	
Discharge from (ward/hospital)	

Awaiting Care Package?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Details of the planned care package:

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

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NHS Number	
Patient Name	

FOR AUTHORISATION BY DN CDL or TISSUE VIABILITY

Date order received:

Roho/ Starlock ordered: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Prescriber able to set up Roho/ Starlock: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Comments re Roho/ Starlock order:			
Contact with prescriber	Date	CDL/TVN	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 ongoing communications

Date	Issue	Action	What next