**Restricted / Specialist dressings – Authorisation Form**

|  |  |
| --- | --- |
| **Patient Details** | |
| Patient Name |  |
| Patient DOB |  |
| Patient NHS Number |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Requestor Details** | | | | | | | |
| Name |  | | | | | | |
| Job Title |  | | | | | | |
| Location of Requestor (please tick appropriate box) | | | | | | | |
| DN Site |  | GP Practice | |  | | Nursing home |  |
| Telephone no. |  | | Email address | |  | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Wound Details (please tick as appropriate)** | | | | | | | |
| Type | Venous leg ulcer |  | Diabetic foot ulcer | |  | Fungating/malignant wound |  |
| Surgical wound |  | Pressure ulcer | |  | Trauma injury |  |
| Skin graft/donor site |  | Burn | |  | Skin tear |  |
| Hematoma |  | Other | |  |  |  |
| Type of wound bed | Epithelialising |  | Granulating | |  | Sloughy |  |
| Necrotic |  | Infected | |  | Colonised |  |
| If infected, date swab taken? | | |  | | | |
| Level of exudate | Low |  | Moderate | |  | High |  |
| Duration of wound |  | | | Size of wound | |  | |
| Further information (please provide any other relevant information) |  | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current/previous dressing regime** | | | | |
| Products used  (including primary dressing) | | Duration used | Frequency of change | Reasons discontinued/ not suitable |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **History of oral antibiotics?** | | | |
| Name, dose & frequency | | Duration used | Date started |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of Restricted/Specialist Dressing requested for use** | | | |
| Name of product |  | | |
| Reason for choice |  | | |
| Size of dressing |  | | |
| Frequency of change & expected duration of use |  | | |
| Quantity required |  | Size required |  |

**To be completed by Tissue Viability Nurse / Community IDT Lead / Practice Lead as appropriate:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Approved (please tick) |  | | Declined (please tick) | |  |
| If declined, action required/alternative recommendation: |  | | | | |
| Name |  | | | | |
| Job title: |  | | | | |
| Signature |  | | | Date |  |
| Amcare request authorised (date)  NB: only applicable to restricted dressings | |  | | | |

|  |  |  |
| --- | --- | --- |
| **AMCARE authorisation not required**  **Senior Clinical oversight/authorisation required by Community IDT Lead / Practice Lead**  *Please ensure your Lead has authorised the use of specialist dressings / products and file this form safely for audit purposes.*  **Silver-containing wound dressings:**  Urgoclean Ag  Aquacel Ag  Urgotul Silver  **Specialist wound dressings:**  Flaminal Hydro  Flaminal Forte  Octenilin Solution  UCS Cloths  Debrisoft Lolly  Mepilex  Mepilex Border  Mepilex XT  Urgoclean  Urgostart Plus  Proshield Spray and cream  Viscopaste Bandage |  | **AMCARE authorisation required**  **Authorisation required by Tissue Viability Nurse before AMCARE order can be processed and restricted item used.**  **Restricted wound dressings:**  Acticoat Flex 3  Polymem  ALL NEGATIVE PRESSURE WOUND THERAPY  Renasys  Pico 7  Pico 14  *To obtain Amcare authorisation, please email the completed form to* [*tissueviability@nhs.net*](mailto:tissueviability@nhs.net)  The TVN Team will respond within 2 days.  If the request is urgent, please contact the TVN Team on 01952 670925 |