SBARR Wound Management Referral Form

I IDENTIFICATION	**FACILITY:** **PH No:**	**NAME:**	**DESIGNATION:**	**DATE:**

S SITUATION

Resident Name: _____NHI/DOB:_____

The problem is: ☐ Wound treatment ☐Wound infection ☐ New wound ☐ Incision line ☐ Skin problem ☐ Consultant Recommendation ☐ Other _____

Vital signs - Blood Pressure: Respiration: Pulse: Temperature:

B BACKGROUND

Cause/Type: ☐ Venous ☐ Diabetic ☐ Arterial ☐ Surgical ☐ Trauma ☐ Fungating ☐ Skin tear ☐ Burn

Wound Location: _____ Measurements: Length_____cm Width_____cm Depth_____cm

Wound Base: %_____Granulation %_____Slough %_____Eschar %_____ Epithelial %_____Other_____

Drainage amount over 24hrs: ☐ S ☐ M ☐ L Colour:_____ Odour:☐ Yes ☐ No

Surrounding Tissue: Colour_____ ☐ Oedema ☐ Firmness ☐ Intact ☐ Pallor ☐ Macerated ☐ Exudate ☐ Lesions ☐ Fragile ☐ Healthy ☐ Eczema ☐ Erythema

Indicators of Infection: ☐ Fever ☐ Streaking ☐ Redness ☐ Increased Drainage ☐ Odour ☐ Warmth ☐ Induration ☐ Malaise ☐ Pain

Significant weight loss in the last 6 months:☐ Yes ☐ No Pain/Discomfort:☐ Yes ☐ No

Past Treatment:

_____

Current Treatment:

_____

Lab Results:

_____

Photo attached ☐ List of current medications attached ☐ Allergies (Medication/Dressings):

A ASSESSMENT

Wound seems to be:☐ Healing ☐ Worsening ☐ Remains Stagnant

I think the problem is: _____

I am not sure what the problem is, but the resident is deteriorating ☐

The resident seems to be unstable and may get worse; we need to:_____

R RECOMMENDATION

Change Treatment to:

_____

Start Interventions:

_____

Obtain Labs:

_____

Obtain consult for:

_____

Transfer the Resident to:

_____

	Other:
R REVIEW	

Please send the Referral to:

Dawn French
Tissue viability Specialist Nurse: Dawn.French@bopdhb.govt.nz