Oxford Health
NHS Foundation Trust

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.

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
- 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 ICB.

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	

Oxford Health NHS Foundation Trust

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, 3 days) and a reason for request:	Delivery timeframe requested: SAME DAY ☐ NEXT DAY ☐ 3 DAYS ☐ 5 DAYS ☐ ☐
If a timed delivery is necessary, please provide details:	
DELIVERY INSTRUCTIONS	
Person to contact for the 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 the 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 dependent ☐

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 the day** (Hours)
Time in chair (Hours)	**Night only** (Hours)	**Day** (Hours)

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

NHS Number	
Patient Name	

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Equipment to be requested

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 ☐	Repose Mattress Topper ☐

ROHO Mattress Topper ☐ NB clinician will need to set this up and order a base mattress	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 ☐	Roho ☐	Vicair Vector 02 ☐	Starlock ☐

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) ☐	Petite ☐	Standard ☐	Bariatric ☐
Reason for heel lift boot request:			

NHS Number	
Patient Name	

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

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

Planned date of discharge	
Discharge from (ward/hospital)	

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

NHS Number	
Patient Name	

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FOR AUTHORISATION BY DN ADNS or LOCALITY LEADS

Date order received:

Equipment authorised:
(YES):

Delivery timeframe authorised:

SAME DAY ☐ 3 DAYS ☐ 5 DAYS ☐

NEXT DAY ☐

Equipment not authorised (NO):

Rational for Decision:

Authorising Signature: Date: