Health and Social Care in Northern Ireland

Western Health and Social Care Trust

NI Wound Care Formulary Product Feedback Form	
Reporter Details *Name and Professional Address:*	
Postcode:	*Tel. No:*
Speciality/Job Title: *Email Address:* *Signature:*	
Product(s) Details (please indicate clearly the wound management product that feedback is being provided on by underlining or circling the name)	
Primary Dressing Details *Name:* *Product Type:* *Size:* *Batch Number:* *Expiry Date:*	**Secondary/Concurrent Dressing Details** *Name:* *Product Type:* *Size:* *Batch Number:* *Expiry Date:*
Wound Details	
Wound Type, i.e. leg ulcer, pressure sore, etc: *Bed:* *Exudate Levels* *Site:* *Size:* *Surrounding Skin:* *Odour:* *Pain:* *Duration of Wound:*	*Infected?:* *Antibiotics?:* *Any Other Relevant Information:*
For RWMPG Use Only:	
Date Received: Repeat Issue? Appropriate Dressing In Situ? Additional Information: Action Required:	

Health and Social Care in Northern Ireland

Western Health and Social Care Trust

NI Wound Care Formulary Product Feedback Form	
Describe the specific problem that the patient has encountered with the dressing:	
Action Taken:	
Date of suspected problem:	
Risk Assessment:	
Do you consider the problem to be serious? *If yes, please indicate why the problem is considered to be serious (please tick all that apply):* *Involved or prolonged in-patient hospitalisation* *Involved persistent or significant disability or incapacity* *Medically significant; please give details:*	
Patient Outcome	
Recovered	
Recovering	
Continuing	
Other; please give details:	
Please forward completed forms to:	
Jenny Mullan Lead Nurse Tissue Viability Service Clinical Audit Room 2 Altnagelvin Hospital 51 Glenshane BT 47 6SB Road jennifer.mullan@westerntrust.hscni.net Tel: 028 71345171 ext 5620	