island health

LOWER LEG WOUND CLINIC PHYSICIAN REFERRAL FORM

Patients will be contacted directly for an appointment by the Clinic

Fax: 250-519-1514 Phone: 250-519-1513

PLEASE NOTE THAT THIS CLINIC IS UNABLE TO PROVIDE EMERGENCY SERVICES

Date_____

Patient Name_____

Birth Date_____
Day-Month-Year

PHN #_____

Patient Telephone_____

Home Address _____

_____

_____

Cognition/Communication Challenges: Yes ☐ No☐

***Please indicate if someone other than patient should be contacted**

Alternate Contact _____

Relationship _____

Phone Number_____

Referring Physician (full name)_____

Telephone _____**Fax:**_____

Family Doctor (full name)_____

MSP_____

Specialists (full name)_____

_____

_____

Physicians Copied On Consultation

Physician (full name) _____

Telephone _____**Fax:**_____

-MUST COME BY WHEELCHAIR OR STRETCHER IF NOT AMBULATING-

Date of onset_____

Wound location on lower leg (circle site): toes heel plantar foot dorsal foot ankle shin calf

Is patient currently receiving Home and Community Care Nursing for dressings (circle) yes no

Edema(circle): unilateral bilateral

Necrosis/Gangrene Yes No (Dry Wet)

Antibiotic Treatment _____

Co-Morbidities:_____

_____

Diabetes: Yes ☐ No ☐ Duration _____**Years**

Chronic Renal Disease: Yes ☐ No☐ Dialysis: Yes ☐ No ☐

INFORMATION INCLUDED

Allergy List (required)

Creatinine +EGFR (required)

Hgb A1C (if applicable)

Medication List (required)