The South West Regional Wound Care Program's

Criteria for Interdisciplinary Referrals

	CRITERIA	REFERRAL (Levels of Evidence in Brackets)*
Wounds in General[1-10]	Score of ≤ 11 on the Mini Nutritional Assessment® Screen and/or underlying nutritional deficiencies/concerns or medical conditions that compromise nutrition	☐ Refer to a Registered Dietician ASAP for a nutritional assessment and recommendations (4)
	Presence of or risk of developing a swallowing impairment	☐ Refer to a Speech Language Pathologist ASAP for a swallowing assessment (4)
	History of one or more falls in the past year or identified as a fall risk	☐ Refer to an Occupational Therapist (OT) for a fall risk assessment and prevention recommendations
	Presence of a wound complicated by bacteremia, sepsis, advancing cellulitis or osteomyelitis, requiring antibiotic therapy	☐ Refer to an Infectious Disease Specialist for assessment and recommendations (1B)
	To prevent or manage pain associated with debridement	☐ Refer to a Pain Management Specialist (4)
	Presence of necrotic tissue in a wound that requires urgent debridement secondary to the presence of advancing cellulitis/sepsis, increased pain, exudates and odor, or for debridement that is beyond the scope of practice/competency of primary care providers	☐ Refer to a Physician that specializes in wound care or a General Surgeon for debridement (4)
	Wounds that meet one or more of the following **FUN** criteria: • **F (Frequency) -** Frequency of dressing changes has not decreased to three times per week by week three • **U (Unknown) -** The cause (etiology) of the wound is unknown, or the nurse is unsure of best practices • **N (Number) -** The surface area of the wound has not decreased by 20-30% in three weeks of treatment, or there is not an ongoing decrease or reduction in wound surface area at each three week interval	☐ Refer to Enterostomal Therapy Nurse (ET)/Wound Care Specialist (WCS)

	OR: • To perform vascular assessment to rule out vascular compromise and/or to direct compression therapy in those with lower limb ulcers and/or edema (4) • Conservative sharp debridement of necrotic tissue and/or callus (4)	
	Signs of a malignant wound	☐ Refer to the person's primary care provider, a general surgeon, or a Dermatologist for a wound biopsy
	Psychosocial barriers associated with pain and/or barriers impeding care plan goals	☐ Refer to a Social Worker or Psychologist to address barriers when identified, to help develop coping strategies, and to link to community supports
Pressure Injury[2-3]	Braden Risk Assessment Scores of ***2 or less*** in any of the following domains: a. Sensory perception b. Activity c. Mobility d. Friction/shear	☐ Refer to an OT ASAP for those at risk for pressure injury development and those with current pressure injuries for assessment and recommendations (2B) including, but not limited to: • High specification foam mattress for those deemed moderate risk (1A) • Choosing an appropriate support surface (4) • Ongoing monitoring and evaluation of support surfaces (4) • Pressure management of heels while in bed (3) • Provide a seating assessment if the pressure injury is on a seating surface (4)
	Person uses a wheelchair or is wheelchair bound	☐ Refer to an OT (4)
	Person has a neurological condition which significantly impairs their independent mobility, i.e. a spinal cord injury, multiple sclerosis, stroke, muscular dystrophy, acquired brain injury, etc.)	☐ Refer to an OT (4)
	Urinary or fecal incontinence negatively affecting skin integrity or wound healing	☐ Refer to a Nurse Continence Advisor for assessment and recommendations
	Large, deep pressure injury, i.e. over an ischeal tuberosity	☐ Refer to a Plastic Surgeon for consideration of skin graft/flap (4)
	Significant Peripheral Arterial Disease and a pressure injury on a lower limb	☐ Refer to a Vascular Surgeon for consideration of revascularization surgery

	Presence of a pressure injury and limited mobility and/or dependency for transfers or deterioration in activity levels	☐ Refer to a PT (4) ASAP for:
		• Assessment of pain, to determine underlying disease (2B)
		• Assessment of any existing pressure injuries(1A)
		• To rule out vascular compromise in injuries of lower extremities (4)
		• For pressure management of heels while in bed (3)
		• To optimize mobilization for people with buttock or trochanter injuries (4)
		• To implement appropriate adjunctive therapies:
		  ○ EST (1B)
		  ○ Warming Therapy (1B)
		  ○ Growth Factors (1B)
		  ○ Pulsed Radio Frequency Stimulation (2)
		  ○ Ultraviolet Light C (2A)
		  ○ Ultrasound Therapy (2)
		  ○ Negative Pressure Wound Therapy (NPWT) (4)
		  ○ Skin Equivalents (4)
		  ○ Hyperbaric Oxygen Therapy (HBOT) (4)

Diabetic/Neuropathic Foot Ulcer[4-8]	Diagnosis of diabetes	☐ Refer to the primary health care provider for annual (and more frequent depending on risk) foot exams (4) and foot risk classification (4)
	Presence of a diabetic foot ulcer and/or loss of protective foot sensation where pressure redistribution or offloading is required	☐ Refer to a foot specialist, i.e. an Orthotist, Chiropodist, Pedorthist, or Podiatrist, ASAP for a foot and footwear assessment and consideration of adaptive foot wear (1A-4)
	Impaired glucose control (HgbA1C $\leq$ 7) and/or underlying nutritional deficiencies, medical conditions and/or concerns at present	☐ Refer to a Certified Diabetes Educator ASAP for diet, nutrition and lifestyle counseling to address factors that may be affecting healing (2)
	Presence of an altered gait pattern, history of experiencing a fall in the past year or inappropriate footwear	☐ Refer ASAP to a PT for assessment of gait and/or need for gait aids and footwear (1A-4)
	Impaired functional status impacting ability to carry out care plan or impeding healing	☐ Refer ASAP to an OT for assessment of functional status (3)
	Presence of a diabetic foot ulcer whose surface area has not reduced 50% at four weeks or completely closed at 12 weeks	☐ Refer to a PT (4) for assessment and consideration of adjunctive therapies, i.e.: • EST (1A) • HBOT (1A) • Biologically active dressings (1B) • NPWT (1B)

	Uncontrolled neuropathic pain	☐ Refer to a PT (4) or other qualified health professional for EST (1A) or, if available, to a center that can provide HBOT (3)
	Presence of a wound that probes to bone and/or where osteomyelitis is suspected	☐ Refer to an Orthopedic Surgeon and/or Infectious Diseases Specialist for consultation (2A-3)
	Presence of a foot deformity that places the person at risk or has contributed to the development of a diabetic/neuropathic foot ulcer	☐ Refer to an Orthopedic Surgeon for consideration of prophylactic or corrective surgery, i.e. Achilles tendon lengthening, arthroplasty, bunionectomy, tendon tenotomy, etc.
	Significant Peripheral Arterial Disease and a foot ulcer	☐ Refer to a Vascular Surgeon for consideration of revascularization surgery
Leg Ulcer[9-10]	Presence of a fixed ankle joint or impaired calf muscle pump function in the presence of edema	☐ Refer to PT ASAP for calf muscle pump exercises and/or ankle range of motion exercises (1)
	Impaired functional status impacting ability to carry out care plan, i.e. impaired cognition, impaired motor skills, etc.	☐ Refer to OT ASAP for assessment of functional status and ability to manage self-care (3)
	A leg ulcer that is >5cm^{2}or >6 months duration on admission, or a leg ulcer that has not completely closed at three months	☐ Refer to PT or other qualified health professional for: • Therapeutic Ultrasound (1) • Intermittent pneumatic compression (1) • HBOT (1) • EST (2)
	Presence of an arterial leg ulcer with moderate to severe neuropathic pain	☐ Refer to PT or other qualified health professional for a trial of EST (2)
	Implementation of graduated compression bandaging/garments	☐ Refer to PT ASAP for education regarding wearing and maintenance of compression garments, elevation of affected limb when at rest, early referral at first sign of skin breakdown, appropriate skin care, avoidance of trauma to legs and need for life-long compression (3)
	Person cannot don/doff their compression stockings independently, and there are no family, friends, neighbors to assist	☐ Refer to OT for adaptive devices and/or to a personal support worker for assistance with this activity (4)
	Suspected skin sensitivity reactions	☐ Refer to a Dermatologist for patch testing (2)
	Superficial venous disease	☐ Refer to a Vascular Surgeon for venous surgery followed by graduated compression hosiery (3)

*Levels of evidence are based on those utilized by the Registered Nurses' Association of Ontario in their Best Practice Guidelines, and the Canadian Association of Wound Care in their Best Practice Recommendations (see below)

Level of Evidence	Definition
1A	Evidence obtained from meta-analysis or systematic review of RCTs
1B	Evidence obtained from at least one RCT
2A	Evidence obtained from at least one well-designed controlled study without randomization
2B	Evidence obtained from at least one other type of well-designed quasi-experimental study without randomization
3	Evidence obtained from well-designed non-experimental descriptive study, such as a comparative study, correlation study, and/or case study
4	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authority

RCT = randomized controlled trial

References

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5. Registered Nurses' Association of Ontario (2004). Reducing foot complications for people with diabetes. Toronto, Canada: Registered Nurses' Association of Ontario.
6. Orsted HL, Searles G, Trowell H, et al. Best practice recommendations for the prevention, diagnosis and treatment of diabetic foot ulcers: Update 2006. Wound Care Canada. 2006;4(1):57-71.
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10. Burrows C, Miller R, Townsend D, et al. Best practice recommendations for the prevention and treatment of venous leg ulcers: Update 2006. Wound Care Canada. 2006;4(1):45-55.