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| **DIABETIC FOOT ULCER REFERRAL FORM** |
| Please complete all **FOUR** sections, **ATTACH** all related documents and **FAX** to the PCDSP at **519-645-6961**. |
| **1. PATIENT INFORMATION** Affix LABEL or complete: | **2. REFERRING PHYSICIAN** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_J#/PIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | *Please print or use a stamp:* |
|  |
| **3. MANDATORY – PRIMARY REFERRAL CRITERIA – TYPE 2 DIABETES , A1cv >8% AND**  *Patients must meet one of the following criteria (check A, B or C):* |
| **❑ A.** Active diabetic foot ulcer x 8 weeks & CCAC Wound Care in place |  **❑ B.** No family physician  | **❑ C.** Active diabetic foot ulcer, transitioning from specialist/acute care (Vascular, ER, ID, Ortho) |
|  |
| **4. PATIENT / TREATMENT HISTORY AND INVESTIGATIONS:** |
| **Duration of ulcer:****Current or recent antibiotics prescribed for ulcer:****Brief history:** | **Supporting Documents:** *Send copies of the following, if not available on Powerchart:***❑** ABPI done at a vascular lab**❑** Recent laboratory investigations including: CBC, A1c, Electrolytes, eGFR, Serum Creatinine, ACR, ALT**❑** Imaging of involved limb ( X-Ray, MRI. CT, Bone Scan) **❑** EKG**❑** Medication list**❑** Consultation note(s)**❑** Wound swabs**❑****❑****❑** |

**Additional notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Thank you for your referral!***

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Please ensure contact information is current.***