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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.***