

Lower Limb Wound Prevention & Treatment Clinic

Patient Information		Date of Referral:	
Name: (First, Last)		Address:	
Date of Birth:		OHIP #:	
Phone: (H) (M)		Email:	
Language:	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____		
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Gender Identity: _____		
Identifies as:	<input type="checkbox"/> First Nation <input type="checkbox"/> Metis <input type="checkbox"/> Inuit <input type="checkbox"/> Non-Indigenous		
Patient provided verbal consent to participate in Team Care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient provided verbal consent for Team Care to leave a confidential voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please note: to be eligible for this program patient MUST be diagnosed with Diabetes, Peripheral Artery Disease and/or an Active Lower Limb Wound

Services Requested - Please identify requested services by checking the boxes.

Triage Level:

- Non-Critical Critical**
****Please send patients who are medically unstable or have gotten worse in the past 24hrs to the emergency department.****

Primary Wound Detail:

- Type of wound:
- Venous Arterial Diabetic Traumatic
 Maintenance Healable Non-Healable
 Other: _____
- Location of Wound: _____
- Size of Wound (cm): _____
- Has the wound been non-healing for more than 2 weeks? Yes
 No Unknown
- Evidence of Infection?
 Yes No Unknown

Diagnosed Conditions:

- End Stage Renal Disease
 High Blood Pressure
 High Cholesterol
 History of Foot Ulcer
 Peripheral Artery Disease (PAD)
 Peripheral Neuropathy
 Type 1 or Type 2 Diabetes
- **Please attach patient profile and blood work (if available) along with referral form****

Reason for Referral:

- Multiple hospital admission, clinic and/or ED visits
 Resides in a high priority neighbourhood (N8H, N8X, N8Y, N9A, N9B, N9C, N9Y)
 Experiencing homelessness or living in social housing
 Other social needs (access to transportation or no OHIP, etc.)

Additional Information:

Provider Stamp: (Check off site of referral origin)	<input type="checkbox"/> ED or Hospital d/c <input type="checkbox"/> Ontario Health @Home <input type="checkbox"/> weCHC/Diabetes Wellness <input type="checkbox"/> Primary Care/Urgent Care Clinic <input type="checkbox"/> Shelter Health/Homelessness & Housing Help Hub (H4)
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In partnership with: