Primary Care Diabetes Support Program
P.O. Box 5777, Stn B
London, ON N6A 4V2
Tel: 519-646-6000 ext. 67268
**Fax: 519-645-6961**

# 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: _____<br>J#/PIN: _____<br>Gender: _____<br>Date of Birth: _____<br>Health Card #: _____<br>Telephone #: _____<br>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:**<br><br>**Current or recent antibiotics prescribed for ulcer:**<br><br>**Brief history:** | **Supporting Documents:**<br>*Send copies of the following, if not available on Powerchart:*<br><br>❑ ABPI done at a vascular lab<br>❑ Recent laboratory investigations including: CBC, A1c, Electrolytes, eGFR, Serum Creatinine, ACR, ALT<br>❑ Imaging of involved limb ( X-Ray, MRI. CT, Bone Scan)<br>❑ EKG<br>❑ Medication list<br>❑ Consultation note(s)<br>❑ Wound swabs<br>❑<br>❑<br>❑ |

**Additional notes:** _____

_____ ***Thank you for your referral!***

**Date:** _____ ***Please ensure contact information is current.***