

***Majority of our physicians have GP focused practice designation. If you are a rostered model practice,
WE'LL DO OUR BEST to book your patient with one of our focused practice designated physicians.***

Please circle: FHO or FHN

*****All patients who are accepted by the PCSDP Wound Care Program will also have their Glycemia assessed and managed as part of our Interprofessional Wound Care Program mandate**

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: Name: _____ J#/PIN: _____ Gender: _____ Date of Birth: _____ Health Card #: _____ Telephone #: _____ Family Physician: _____	2. REFERRING PHYSICIAN <i>Please print or use a stamp:</i>
3. MANDATORY – PRIMARY REFERRAL CRITERIA – TYPE 2 DIABETES, A1c > 8% AND <i>Patients must meet ONE of the following criteria (check A, B or C):</i>	
<input type="checkbox"/> A. Active diabetic foot ulcer x 8 weeks & CCAC Wound Care in place	<input type="checkbox"/> B. No family physician
<input type="checkbox"/> 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: <i>Send copies of the following, if not available on Power chart:</i> <input type="checkbox"/> ABPI done at a vascular lab <input type="checkbox"/> Recent laboratory investigations including: CBC, A1c, Electrolytes, eGFR, Serum Creatinine, ACR, ALT <input type="checkbox"/> Imaging of involved limb (X-Ray, MRI, CT, Bone Scan) <input type="checkbox"/> EKG <input type="checkbox"/> Medication list <input type="checkbox"/> Consultation note(s) <input type="checkbox"/> Wound swabs

Additional notes: _____

_____ *Thank you for your referral!*

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