

WOUND HEALING CLINIC REFERRAL FORM

Vancouver General Hospital

3rd Floor, Station 4 - 2775 Laurel St. Diamond Health Centre, Vancouver, BC, CA, V5Z 1M9

Phone: 604-875-5255 **Fax:** 604-875-4476

Please fill out form completely to avoid appointment delays.

Today's Date: _____

PATIENT DEMOGRAPHICS	
Patient Name:	Preferred name:
Date of birth:	PHN:
Address:	
Primary phone number: Home: _____ Mobile: _____ Work: _____	
Alternate contact and relation to patient: _____	
Interpreter required? <input type="checkbox"/> No <input type="checkbox"/> Yes Preferred language: _____	
REFERRAL DETAILS	
Please check if applicable - all <u>must</u> apply to be considered:	
<input type="checkbox"/> Patient has an OPEN wound	
<input type="checkbox"/> Non-healing for more than three months	
IF THESE DO NOT APPLY, THE REFERRAL WILL BE DECLINED.	
Reason for referral:	
<input type="checkbox"/> Pressure ulcer <input type="checkbox"/> Venous ulcer <input type="checkbox"/> Traumatic wound <input type="checkbox"/> Post-surgical failure to heal <input type="checkbox"/> Unknown	
Please refer to vascular surgery if a known arterial wound.	
Location of wound(s):	
How long has the wound(s) been open?	
Is the patient receiving community wound care? <input type="checkbox"/> No <input type="checkbox"/> Yes. Where? _____	
Current wound care plan, if known: _____	
ADDITIONAL INFORMATION	
Allergies (please list, if any):	
Precautions (ie. MRSA):	
Mobility status: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Stand-by assist <input type="checkbox"/> Requires wheelchair <i>or</i> <input type="checkbox"/> Ceiling lift <input type="checkbox"/> Para/quad	
<ul style="list-style-type: none"> ▪ Non-ambulatory patients must be able to self-transfer (ie. from wheelchair) or have someone with them. ▪ Patients able to be treated without a transfer will be considered. ▪ Please note that our clinic space cannot accommodate stretchers. 	
Please attach the following: <ul style="list-style-type: none"> ▪ Brief medical history and relevant specialist consult notes ▪ Pertinent results including lab (A1C, Prealbumin), pathology report, vascular study and imaging. ▪ Medications list 	
REFERRING PROVIDER DETAILS	
Provider Name:	MSP Billing #:
Phone Number:	Fax Number:

We will review the referral and contact the patient directly for booking. If we are unable to reach the patient, we will notify your office. If the referral is not accepted, we will notify your office with the reason for decline.