fraserhealth

FOOT WOUND CLINIC PHYSICIAN REFERRAL

Abbotsford Regional Hospital

AMXX106655A New: Apr 28/16

Complete form and fax to General Day Care: 604 - 851 - 4766

You will receive a fax confirmation once your patient has been booked for an appointment.

DATE OF REFERRAL: ______________________________

Patient Information

Surname	First Name	Middle
Address:		
Home Phone:	Cell Phone:	
PHN #:		
☐ MRSA Positive	☐ MDRO Positive	
Interpreter required? - Language:		

Referring Physician

Name:	
Address:	
Tel #:	Fax #:
MSP Billing #:	
Send report to: ☐ Referring Physician ☐ Other	

Reason for Referral: Please tick box

☐ Diabetic Foot Ulcer
☐ Arterial Ulcer
☐ Chronic venous ulcer (>2 months duration)
☐ Other:______________________________

Location:

☐ Left ☐ Right ☐ Bilateral

(☐ Lower Leg ☐ Ankle ☐ Foot ☐ Heel ☐ Toes)

Brief History:

____
____
____
____

Home Health Care Client? ☐ Yes ☐ No **Current Treatment:** ______________________________

Recent Diagnostics and Lab Tests: Please attach reports (Please ensure there is a recent EGFR)

☐ A1C ☐ Creatinine ☐ eGFR

☐ X-ray (weight bearing) ☐ Bone scan ☐ Ultrasound ☐ CT Scan ☐ MRI

Clinic Use Only

☐ **Referral Accepted**

Appointment Urgency

☐ Appointment < 1 week ☐ Appointment within 1 2 weeks ☐ Appointment > 2 weeks

☐ **Referral Declined** ______________________________

Surgeon Signature ____________________ **Date of Triage** ____________________