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** _____