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WOUND CARE REFERRAL
AMBULATORY WOUND CARE CLINIC

Form ID: Rev: April 27, 2020

PATIENT INFORMATION:
(Please Use Black Ink)

Phone: 604-592-2040
Fax: 604-528-5439

Patient's Name: ____________________ **Gender:** ________
Last First Middle

Date of Birth: ______ / ______ / ______ **PHN:** ____________ **Insurance:** ________
(DD/MM/YYYY)

Address: ____
Street City Province Postal Code

Contact Method Primary: ________________ **Alternate:** ____________

REFERRAL INFORMATION:

Priority: ☐ **Routine** ☐ **Urgent**

Dressing location: Wound, Tube or Nephrostomy

____

PIXALERE NUMBER: ____________________

Referring Health Care Provider:
Name: ____________________
Title: ____________ **Source:** ____________
MSP #: ____________________
Phone: ____________ **Fax:** ____________

Isolation Precautions: ☐ **Airborne** ☐ **Contact** ☐ **Droplet** **ALERT:** ____________

DOCTORS ORDER OR WOUND CARE CLINICIAN RECOMMENDATIONS ATTACHED ☐

MEDICAL REASON FOR URGENCY: ____

RELEVANT MEDICAL OR OTHER HISTORY: ____

CURRENT WOUND TREATMENT PLAN and DRESSING CHANGE FREQUENCY: ____________

DRESSING PRODUCTS PREVIOUSLY USED: ____

Referring Health Care Provider Signature: ____________________ **Date:** ____________

****PATIENT MUST BE ABLE TO SELF TRANSFER WITH OR WITHOUT ASSISTANCE OF FAMILY/CAREGIVER****

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