**Chronic Wound Clinic Referral**

2/531-533 Kingsway, Miranda, Level 1

**NOTE: This clinic only operates on Thursday afternoons**

**For enquiries leave a message on XXXXXXXXXX & we will call back**

**This clinic provides an ambulatory care clinic and tele-health appointments.**

**All initial appointments will be tele-health.**

**Workup studies** (document or attach):

* Swab reports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* FBC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Iron\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* HbA1c\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* LFT & EUC­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other important studies (useful to have results if already conducted)**

* Has a biopsy been done? Yes (please document results below) No

Histopath results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Venous & Arterial dopplers (for leg ulcers/wounds) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Patient Details**  | **GP / Specialist Referrer Details**  |
| **Name:**  | **Name:**  |
| **DOB:**  | **Practice:** |
| **Address:**  | **Phone:** |
| **Patient phone:**  | **Fax:** |
| **Who do we contact to make this appointment?** |
| **Contact Name & phone: Relationship to patient:** |
| **Referral criteria (these all need to apply, otherwise referral will not be accepted)** Chronic or complex wound Greater than 6 weeks duration  Wound is failing to heal despite usual treatment GP has consulted on this wound and approves this referral Patient can attend the clinic- must be able to transfer with minimal assistance of one person ORTele-health appointment required as patient CAN’T transfer easily with one or less people |
| **Past History:** Please attach a GP patient health summary with this referral which includes:* Past History
* Current Medications
 |
| **Allergies** (list specific allergen/s and reaction/s) Nil allergies…………………………………… Latex……………………………………..…….. Tape……………………..….…………………Local anaesthetic……………………………... Iodine………………………………………….. Medications………………………..………… Other…………………………………………….…………………………………………………… ………………………………………………….. |
| **Does the patient have any of the following:**  Diabetes  Anaemia Anticoagulants Arterial disease  Venous disease  Immunosuppresents Lymphoedema  Renal Failure  Steroids Heart Failure  Peripheral Neuropathy  ChemotherapyHypertension  Dementia  Malignancy Previous leg ulcers- If yes for previous ulcers, what type and how long ago: …………………………………………………………………………………………………………. …………………………………………………………………………………………………………... |

Please mark location of all current wound/s



**Details of current wound/s needing review:**

|  |
| --- |
| How many wounds do you want this clinic to focus on? Please number on above drawings.Duration of each woundDressings- frequency & typePain- severity & typeHave any specialists been involved in care? What did they do?Who is managing this wound? (include contact details)Has the patient’s usual GP been notified of this referral? Yes - if not please do so prior to sending referral. |

**Please fax this form back to 9540 8164.**

***Referrals will be responded to within 1-2 weeks of receiving referral.***