Lower Leg Wound Clinic
Royal Jubilee Hospital
Clinic 3, Diagnostic & Treatment Centre
Phone: (250) 519-1513 Fax: (250) 519-1514 Email: llwc@islandhealth.ca

Lower Leg Wound Clinic Provider Referral Form

All Information Fields are Required for Processing ▪ Completed Forms to be faxed to 250-519-1514

Referral Date _____ **Patient Name _____** **DOB yyyy/mm/dd _____** **PHN_____** **Patient Telephone _____** **Patient Address _____** **_____**	**Is this is a Re-Referral? Y/N _____** ***Please indicated if someone other than the patient should be contacted** **Alternate Contact _____** **Relationship _____** **Telephone _____**

Referring Physician/NP _____ **MSP Number _____** **Telephone _____** **Fax_____** **Primary Health Care Provider _____**	**Specialists/Additional Care Providers to be Copied on Consultations:** **_____** **_____** **_____**

Date of Wound Onset _____ **Wound Location: □ Right □ Left □ Bilateral**

□ necrosis/gangrene present **□ Lower Leg □ Forefoot □ Midfoot □ Hindfoot (Heel)**

Diabetes: Y/N Date Diagnosed _____ Hbg A1C (if applicable) _____

Creatinine & eGFR (include date) _____ Active with Community Health Services? Y/N

Residing in Care Facility? Y/N _____ Independent to Transfer? Y/N _____

Cognition/Communication Challenges? Y/N _____

ARO Alert? Y/N_____ Height/Weight _____

Pertinent Medical History _____

Medications _____

Allergies _____

Non-Ambulatory Patients Must Arrive Via Wheelchair or Stretcher ▪ This Clinic is Unable to Provide Emergency Services