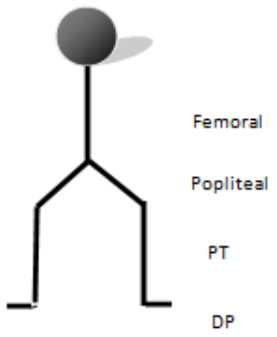
Urgent Vascular Peripheral Artery Disease Clinic (UVPAD) Referral

Inclusion Criteria - Patient must have an ABNORMAL arterial or venous physical exam PLUS one of the following:

☐ Poorly healing lower limb wound(s) or gangrene ☐ Ischemic rest pain

PATIENT INFORMATION	REFERRED BY
Referral Date	Is this a re-referral? ☐ Yes ☐ No
Patient Name	Referring Physician/NP
Date of birth *dd-Mmm-yyyy*	MSP # ☐ Locum
PHN	Telephone
Patient Telephone	Fax
Patient Address	Primary Care Provider ☐ Same as referring practitioner

Pulses



1. ☐ Right ☐ Left ☐ Bilateral ☐ Arterial ulcer/gangrene ☐ venous ulcer ☐ ischemic rest pain
2. Wound/ischemic rest pain location(s) – please circle on diagram
3. Urgency of Referral ☐ < 2 weeks (arterial wound, gangrene, limb threatening ischemia)
   ☐ > 2 weeks (venous ulcer)

   Please note referrals are triaged according to urgency. Referral volumes may affect wait times
4. Indicate the arterial pulses for each location 0-4 as listed below:

   0 = absent 1+ = weak 2+ = normal 3+ = increase normal 4+ = bounding

   Femoral R _____ L _____

   Popliteal R _____ L _____

   Posterior Tibial R _____ L _____

   Dorsalis Pedis R _____ L _____
5. On Anticoagulation? ☐ Yes ☐ No Medication type/dose_____

Required Diagnostic Testing – Tick off to Confirm Referring Provider has Ordered (outstanding diagnostics may delay appointment)

Venous Patients:

☐ Venous reflux study of deep, superficial and perforator veins (includes non-urgent DVT study)

☐ Bilateral Resting Arterial Doppler (Ankle Brachial Index)

Arterial Patients:

☐ CTA with run-off (have this completed at your local hospital prior to UVPAD visit if referral is for limb threatening ischemia

Information Required for Processing

Creatinine & eGFR (include date) _____ Active with Community Health Services? ☐ Yes ☐ No Height/Weight _____

Residing in Care Facility? ☐ Yes ☐ No _____ Independent to Transfer? ☐ Yes ☐ No _____ ARO Alert? ☐ Yes ☐ No _____

Wound Care Done By: ☐ CHS ☐ Patient/Family ☐ other _____Cognition/Communication Challenges? _____

Pertinent Medical History _____

Medications _____

Allergies _____

ROUTING

Fax Completed Referral to Royal Jubilee Hospital, Clinic 3, Diagnostic & Treatment Centre

Phone:(250) 519-1513 **Fax:(250) 519-1514** **Email: llwc@islandhealth.ca**

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