

Victoria Pressure Injury Program Referral

Patient Information (Label if available)

Name: _____

Birthdate: _____

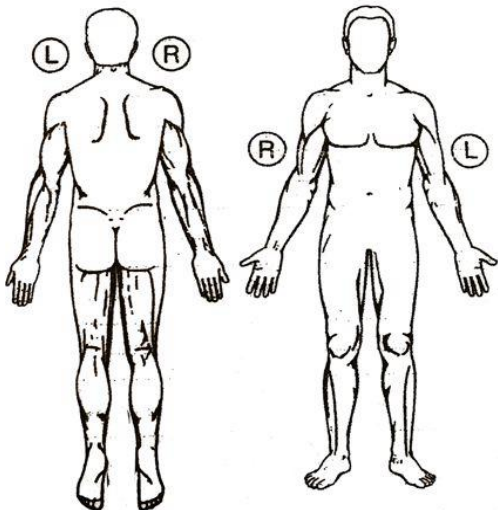
PHN: _____

- This is a non-emergent clinic; patients are typically seen within 1-3 weeks
- Patients should be followed by Community Health Services prior to referral
- Initial contact will be made with the patient and Community Health services for further history and details.
- If this is a re-referral, please indicate the reason for re-referral

Date of Referral: _____ ☐ New Patient ☐ Re-Referral

Patient Information:	Daytime Phone: _____	Cell Phone: _____	Email: _____
Provider Information:	Referring Provider Name: _____		Primary Care Provider: _____
	Community Health Services: _____		Contact Number: _____

AREA OF PRESSURE INJURY FOR TREATMENT



1. SCI Injury Level: _____ Year: _____
Cause: _____
Or list any contributing comorbidities: _____
2. Reason for referral: (check all that apply)
☐ Debridement ☐ Wound Assessment ☐ Other: _____
3. Wound #1 Location: _____
Size: L: _____ W: _____ D: _____
Undermining: Yes No
4. Wound #2 Location: _____
Size: L: _____ W: _____ D: _____
Undermining: Yes No
5. Wound #3 Location: _____
Size: L: _____ W: _____ D: _____
Undermining: Yes No

Current Wound plan of care: (Including frequency): _____

Wound care done by: ☐ Community nurse ☐ Client/caregiver Contact Precautions: ☐ Yes ☐ No

Hx of aggressive behaviour: ☐ Yes ☐ No Comments: _____

Transfer Method: ☐ Independent ☐ 1-person assist ☐ 2-person assist ☐ Mechanical lift

Wheelchair: ☐ Power ☐ Manual ☐ Caregiver will accompany if necessary

Community Contacts	Name	Phone	Fax
Case Manager			
Home Care Nurse			
Physiotherapist			
Occupational Therapist			
Dietician			
Other			

Completed Referrals to be sent to:

Fax:
250-370-8476

Email:
victoriaostomycareclinic3@islandhealth.ca