OUTPATIENT REFERRAL TO WOUND CARE

Wound Clinic: RN and Dermatology Led clinic at Major's Path Clinic in EZU.
Wound Specialist: Regional Wound Care Specialist found in each Zone.
Community Health Nurse: If patient is not being followed by the Community Health Nurse for this wound, please send a referral to the CHN for the wound to be treated sooner.

REFERRAL DETAILS

Preferred Zone: ☐ Eastern Urban ☐ Eastern Rural ☐ Western ☐ Central ☐ Labrador-Grenfell

Are you referring to the Wound Clinic, Wound Care Specialist, or Ostomy Nurse?

☐ Wound Care Clinic ☐ Wound Care Specialist ☐ Ostomy Nurse

If WOUND CARE CLINIC or WOUND CARE SPECIALIST selected

Reason(s) for Referral:

_____

_____

Is The Patient Being Followed By Another Physician For This Wound?

☐ Yes ☐ No ☐ Unsure

Is The Patient Being Seen By A Community Health Nurse?

☐ Yes ☐ No ☐ Unknown

If No or Unknown:

Send Referral to Community Health Nurse: ☐ Acknowledged

What Is The Size Of The Wound? (L x W x D in cm)

_____

Does the Wound Have Tunneling or Undermining?

☐ Yes ☐ No

If Yes:

Size of Tunneling/Undermining (cm): _____

How Long Has The Patient Had The Wound?

_____

Has The Patient Had Vascular (Arterial) Studies?

☐ Yes ☐ No ☐ Unknown

If Yes:

When were the vascular studies taken? _____

If WOUND CARE CLINIC or WOUND CARE SPECIALIST selected (continued)

Are there any client/site risk safety issues/concerns?

☐ Yes ☐ No

If Yes — please specify (select all that apply):

☐ Is there smoking in the home? ☐ Are there any pets/animals in the home? ☐ Are there firearms or weapons in the home?

☐ Is there medication/substance misuse/abuse in the home?

☐ Does client have known infectious/communicable diseases/bed bugs etc.?

☐ Are there any indicators of aggression/violence at home/hospital? ☐ Did client arrive at facility under Police escort?

☐ Is the client associated with alleged illegal activity? ☐ Does the client reside in a boarding house?

☐ Were there any safety issues while the client was in the hospital? ☐ Does the client live in a high risk/address/neighbourhood?

☐ Other

Does The Patient Have Mobility Issues? ☐ Yes ☐ No ☐ Unknown

If Yes:

Does the Patient Require a Lift or Other Mobility Aids?

_____

Does The Patient Require An Ambulance For Transport?

☐ Yes ☐ No

Please attach images to this referral.

If OSTOMY NURSE selected

Reason for Referral (select all that apply):

☐ New Ostomy Teaching ☐ Old Ostomy Complications ☐ Old Ostomy Follow Up ☐ Problems with Existing Appliance

☐ Problems with Parastomal Skin ☐ Stoma Site Marking ☐ Other

Please Specify: _____

Type of Stoma: ☐ Colostomy ☐ Fistula ☐ Ileal Conduit ☐ Ileostomy

REFERRAL TYPE & COMMENTS

Referral Type: ☐ New Referral ☐ Update to Existing Referral

Comments: _____

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