| | |
|---|---|
| ST JOSEPH'S HEALTH CARE LONDON | **Outpatient Wound Referral Form**<br>Phone: 519-685-4027 x Extension 3<br>Fax: 519-685-4075 |

| **Patient Information** | **Referring Physician** |
|---|---|
| Name | Name: |
| Date of Birth | Fax: |
| Address | Phone: |
| | Address: |
| Phone | |
| OHIP# | Billing number: |
| | |

**History/Description of Problem, including location of ulcers suspected etiology and goals of referral**

**Active Medical Problems:** PLEASE INCLUDE ANY OTHER RELEVANT INFORMATION OR TEST RESULTS INCLUDING MOST RECENT LAB WORK RESULTS (CBC, LYTES, CREATININE, TSH, GLUCOSE, HbA1c IF DIABETIC, LIPID PROFILE, SERUM ALBUMIN, XRAYS, DOPPLER STUDIES

**Current Medications:**

| Allergies | Please circle urgency of request<br>0 1 2 3 4 5<br>Non Urgent Very Urgent |
|---|---|
| Signature of referring provider: | Date: |

| OFFICE USE ONLY: Referral Declined, not appropriate for clinic ☐ | |
|---|---|
| Date Received: | Notes: |

This form will be returned if uncomplete. If the patient requires medical transport, please ensure there is an attendant or family member with the patient as wait times for return may be lengthily. If the patient is not able to provide pertinent medical information or give informed consent for medical procedures, please ensure they are accompanied by a designate.