ST JOSEPH'S HEALTH CARE LONDON

Primary Care Diabetes Support Program
P.O. Box 5777, Stn B
London, ON N6A 4V2
Tel: 519-646-6000 ext. 67268
Fax: 519-645-6961

DIABETIC FOOT ULCER REFERRAL FORM

Please complete all **FOUR** sections, **ATTACH** all related documents and **FAX** to the PCDSP at **519-645-6961**.

1. **PATIENT INFORMATION** Affix LABEL or complete:	2. **REFERRING PHYSICIAN**
Name: ______ J#/PIN: ______ Gender: ______ Date of Birth: ______ Health Card #: ______ Telephone #: ______ Family Physician: ______	*Please print or use a stamp:*

3. MANDATORY – PRIMARY REFERRAL CRITERIA – TYPE 2 DIABETES, A1c ≥ 8% AND
Patients must meet ONE of the following criteria (check A, B or C):

❑ **A.** Active diabetic foot ulcer x 8 weeks & CCAC Wound Care in place	❑ **B.** No family physician	❑ **C.** Active diabetic foot ulcer, transitioning from specialist/acute care (Vascular, ER, ID, Ortho)

4. PATIENT / TREATMENT HISTORY AND INVESTIGATIONS:

Duration of ulcer: **Current or recent antibiotics prescribed for ulcer:** **Brief history:** i	**Supporting Documents:** *Send copies of the following, if not available on Power chart:* ❑ ABPI done at a vascular lab ❑ Recent laboratory investigations including: CBC, A1c, Electrolytes, eGFR, Serum Creatinine, ACR, ALT ❑ Imaging of involved limb (X-Ray, MRI. CT, Bone Scan) ❑ EKG ❑ Medication list ❑ Consultation note(s) ❑ Wound swabs ❑ ❑ ❑

Additional notes: ______

______ ***Thank you for your referral!***

Date: ______ ***Please ensure contact information is current.***

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Nov2020/AM