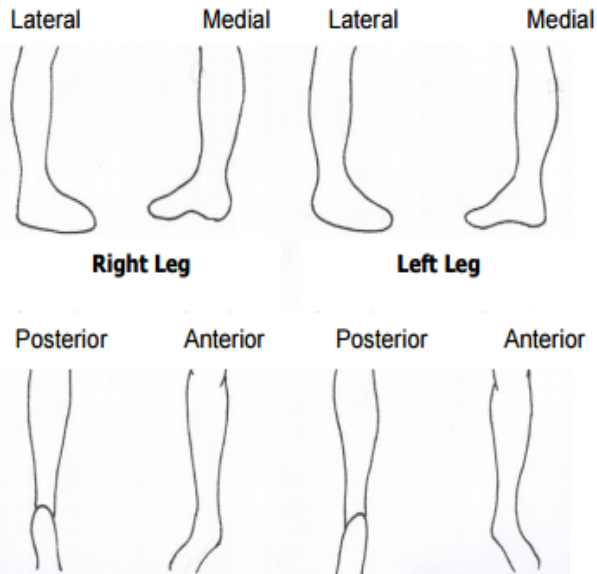


Chronic Wound Assessment Clinic Referral

Phone: 0421 777 602, FAX: 9542 8388
 Address: Level 1, Suite 2, 531-533 Kingsway, Miranda

- This clinic provides an ambulatory care clinic and tele-health appointments
- For ENQUIRIES call 0421 777 602
- Referrals may be faxed to 9542 8388
- We are available reply to enquiries on Tuesdays or Thursdays
- Consultations only on Thursday afternoons: 1pm - 5pm

Patient Details	GP Details	
Name:	Name:	
DOB:	Practice:	
Address:	Phone:	
Patient phone:	Fax:	
Who will be our contact to discuss this appointment?		
Contact Name:	Mobile Phone:	
	Relationship to patient:	
PLEASE NOTE THAT THIS IS A WOUND ASSESSMENT AND ADVISORY CLINIC - NOT A WOUND DRESSING CLINIC		
Referral criteria (all these must apply to qualify)		
<input type="checkbox"/> Chronic or complex wound <input type="checkbox"/> Greater than 6 weeks duration <input type="checkbox"/> Wound is failing to heal despite usual treatment <input type="checkbox"/> GP has consulted on this wound and approves this referral <input type="checkbox"/> Patient can attend the clinic - must be able to transfer with minimal assistance of one person <div style="text-align: center;">OR</div> <input type="checkbox"/> Tele-health appointment required as patient CAN'T transfer easily with one or less people		
PHOTOS OF THE WOUND/S: SEND TO OUR MOBILE NUMBER 0421 777 602 WITH PATIENTS DETAILS + SITE		
Past History:		
Please attach a GP patient health summary with this referral which includes:		
<ul style="list-style-type: none"> • Past History • Current Medications 		
Allergies: (list specific allergen/s and reaction/s)		
<input type="checkbox"/> Nil allergies.....	<input type="checkbox"/> Iodine.....	
<input type="checkbox"/> Latex.....	<input type="checkbox"/> Tape.....	
<input type="checkbox"/> Local anaesthetic.....	<input type="checkbox"/> Other.....	
<input type="checkbox"/> Medications.....		
Current Medical History (these may impair wound healing):		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anaemia	<input type="checkbox"/> Anticoagulants
<input type="checkbox"/> Arterial disease	<input type="checkbox"/> Venous disease	<input type="checkbox"/> Immunosuppressents
<input type="checkbox"/> Lymphoedema	<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Steroids
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dementia	
<input type="checkbox"/> Previous leg ulcers	<input type="checkbox"/> Malignancy	



**Mark
location
of all
current
wound/s:**

What caused the initial wound/s?

How long has the wound/s been present?

What is currently being used to dress the wound/s?

PLEASE ATTACH:

1. Pathology Tests: (these are not essential but may assist determining reason for non-healing)

- Wound Swab reports
- FBC, LFT & EUC
- Iron Studies
- HbA1c
- Wound biopsy

2. ABI/Venous Doppler/Arterial Doppler results/Radiology(if available)

3. GP Referral or GP Health Summary

4. WOUND PHOTOS:

- **should be sent to our Mobile No. 0421 777 602**
- **include a message with Patients Details and site of wound.**
- **no faxed photos as they have very poor resolution**

Please FAX this form with attachments to 9542 8388

Referrals will be responded to within 1-2 weeks of receiving referral.