Integrated Specialist Healthcare
Education & Research Foundation

HealthOne SUTHERLAND

Wound Clinic Referral Form

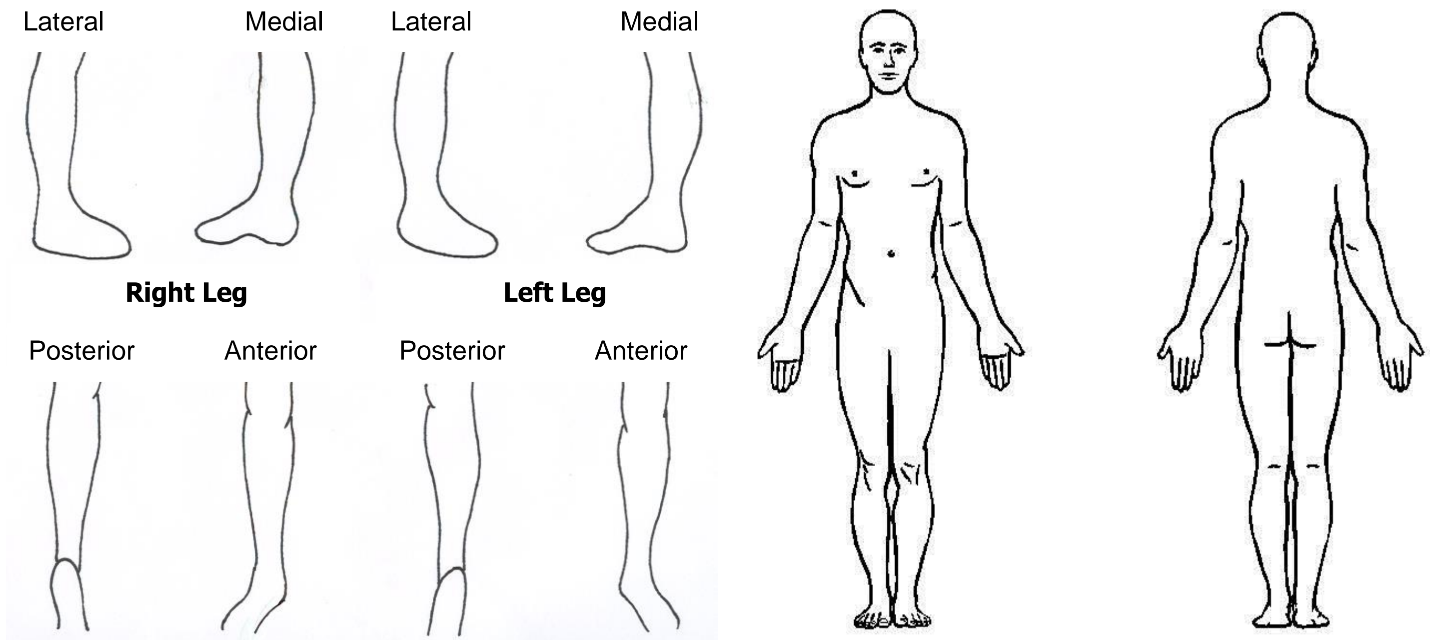
Patient Details	GP / Specialist Referrer Details
Name: ………………………………………………	Name: ………………………………………………
DOB: ………………………………………………	Provider Number: ………………………………
Address: ………………………………………………	Practice: ………………………………………………
………………………………………………………	Phone: ………………………………………………
………………………………………………………	Fax: ………………………………………………
Phone: ………………………………………………	Email: ………………………………………………
Email: ………………………………………………	Preferred method of contact: Fax ☐ Email ☐

Do you have any of the following:

☐ Diabetes | ☐ Arterial disease | ☐ Venous disease | ☐ Previous leg ulcers

If yes for previous ulcers what type and how long ago:

Please mark location of all current wound/s



Details of current wound/s needing review (e.g. duration, cause and who else has reviewed the wound):

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Please email this form back to Seslhd-tshiwcc@health.nsw.gov.au or Fax 9540 8164