NW Wound, Vascular and Limb Preservation Central Intake Fax: 1-855-702-1264

Patient

First Name: _____ Last Name: _____ Male ☐ Female ☐ Identifies As Other ☐

Date of Birth _____ Health Card Number_____ Status or Band Number_____

Phone Number: _____ Alternate Phone Number _____ Cell Phone Number: _____

Home Address: _____ Community Currently Resides In _____

Triage Level

☐ Not Critical ☐ Critical**

***Please send patients who are **medically unstable** or have gotten significantly worse in the last 24 hours to the closest emergency*

Active Offer

Please ask the patient:

What is your Mother Tongue?
□ English □ French □ Other_____

If not ENG/FRE which language are you most comfortable being served in? □ English □ French

Consents

□ Patient has consented to this referral and understands this information will be shared with Wound Care Central Intake and an Advanced Practice Clinician. As a part of this service, Central Intake will route assessments and care plans to other providers in the circle of care.
□ Do NOT share information with: _____

Primary Care/Medical Home

Family Doctor or NP is _____ □ Patient does not have a Primary Care Provider

Follow up Referrals Vascular, Orthopedic, Plastic Surgery etc must be authorized by a Physician or NP
I authorize recommended referrals to be sent on my behalf by Central Intake □ Yes □ No

Patient Setting

Where is patient currently residing?

□ Precariously Housed or Transient □ At Home/In Community
□ Resident of Long-Term Care Facility □ Inpatient at Hospital

If inpatient, what is the expected discharge date? _____

Assessment Preferences

Where should assessment occur? Pick One
□ In person at closest assessor, may require travel to:
□ Virtual (OTN, phone or other)

Primary Wound Detail

□ Client requires Dressing Changes only (must have orders attached) A foot Screen has been completed □ Yes □ No □ N/A

Type of wound (if known) _____ **Size** of wound (cm) _____ Level of **Pain**? (1 least – 10 worst) _____

Has wound been **non-healing** for more than 2 weeks? □ Yes □ No □ Unknown Is there **packing** in the wound? □Yes □ No

Evidence of **Infection**? □Yes □ No □ Unknown **Diabetic**? □ Yes □ No □ Unknown

Anatomic **Location** of Wound _____ **Secondary wounds** □ Yes □ No □ Unknown

Current Wound Care Provider? □ Emergency Dept □ Home Care □ Self/Family □ Other_____

Mobility Concerns**?** □ Cane □ Walker □ Wheelchair – Can Transfer □ Wheelchair – Can't Transfer □ Non Ambulatory

Please print legibly – thank you!

Name **Organization** **Date**

SREFWOUND

Last Update: Aug 25, 2023, Version 3.0