

COMPLEX WOUND CLINIC – REFERRAL FORM

VANCOUVER GENERAL HOSPITAL

Gordon & Leslie Diamond Health Care Centre

3rd Floor, 2775 Laurel Street, Vancouver, BC

Phone: 604-875-5866 ext 5 Fax: 604-875-5861

Please note: Filling out ALL fields is MANDATORY for booking a consult. Please attach all relevant reports including C&S, radiology and pathology reports. INCOMPLETE REFERRALS WILL NOT BE PROCESSED.

DATE: _____ PATIENT: _____ M / F

BIRTHDATE: _____ PHN: _____ PIX ID NO. _____

ADDRESS: _____

HOME PHONE: _____ ALTERNATE PHONE: _____

REASON FOR REFERRAL: _____

LOCATION OF WOUND:

Traumatic Wound? _____

Post-op wound failure to heal? _____

Etiology? _____

How long? _____

Wound size: _____

Wound Depth: _____

Previous Treatments used? _____

Is patient ambulatory?

Yes _____

No _____

Is patient wheelchair dependent?

Yes _____

No _____

Is patient coming by ambulance/stretchers?

Yes _____

No _____

MRSA positive?

Yes _____

No _____

Interpreter required?

Yes _____

No _____

Language spoken: _____

Wound History: _____

REFERRING DOCTOR: _____

BILLING NO.: _____

PHONE NUMBER: _____

FAX NUMBER: _____

Please note that this is an outpatient clinic and we are unable to accommodate acute care inpatients from any facility. You are welcome to refer patients from extended care hospitals.

If your patient requires any self-care, he/she must have someone accompany him/her to the clinic appointment.