Belleville and Quinte West Community Health Centre

HIGH RISK FOOT AND WOUND CARE INITIATIVE REFERRAL FORM

****Please note that all incomplete forms will be returned to the referring provider for more information and all client referrals will be triaged based on the information provided. ****

Referring Provider: _____

Clients Current Family MD/NP:_____

Fax Number **(REQUIRED)**: _____ Phone Number: _____

Date Referral Sent: _____Request communication back? ☐ Yes ☐ No

Client Information

Name (as it appears on Health Card):_____, _____, _____
Last First Initial

Preferred Name: _____

Health Card Number: _____ Date of Birth: _____
(Number and Version Code) (DD/MM/YYYY)

Sex as listed on Health Card: _____Gender Identity: _____

Address: _____, _____, _____, _____
Street Apt. City/Town Postal Code

Clients Primary Phone: ( ) _____ Alternate Phone: ( ) _____

This initiative is specifically designed to provide high risk wound and foot care for individuals who have high risk chronic illness and advanced foot problems that do not have any health insurance coverage, or for those who have exhausted their insurance coverage for wound and foot care services. Please confirm that this client does not have any coverage.

This client **does not** have any health insurance coverage/benefits (ie. Private, DVA, etc.) For chiropody. CONFIRMED _____ (Referring Provider Initials)

Client has: ☐ Diabetes ☐ Vascular Disease (M.I. / Stroke, PVD, etc.) ☐ Other Chronic Illness

Referral for: ☐ Open wound/foot ulcer or infection (high priority)

☐ Advanced foot problem (i.e. heavy calluses, corns, fragile skin with pressure lesions, thick nails, cracked skin, reddened areas with localized foot pain, etc.

Details of Foot Problem: _____

_____

_____

_____

Please Note: We do not provide ongoing routine nail or foot care.

Please Fax **COMPLETED** Referral to **613-962-5669**

FOR OFFICE USE ONLY:

File #: _____ **Triaged:** _____ **Appointment Scheduled:** _____