COMPLEX WOUND CLINIC – REFERRAL FORM

VANCOUVER GENERAL HOSPITAL
Gordon & Leslie Diamond Health Care Centre
3rd Floor, Reception
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 visit.

Please attach all relevant reports including C&S, radiology and pathology reports.

INCOMPLETE REFERRALS WILL NOT BE PROCESSED.

DATE: _____ PATIENT NAME: _____

BIRTHDATE: _____ PHN: _____ PIX ID NO. _____

ADDRESS: _____

HOME PHONE: _____ ALTERNATE PHONE: _____

REASON FOR REFERRAL: _____

LOCATION OF WOUND: _____. **ETIOLOGY:** _____

How long has wound been present? _____

Wound size (width x length, cm): _____ **Wound Depth** (cm): _____

Previous Treatments used _____

Does the patient smoke?	Yes _____ How many/day? _____	No_____
Is patient wheelchair dependent?	Yes _____	No_____
Is patient coming by ambulance/stretcher?	Yes _____	No_____
Is the patient compliant with suggested treatments?	Yes _____	No_____
Interpreter required?	Yes _____	No_____
Language spoken: _____		

Wound History and current treatment: _____

_____

_____

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.