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**