Hôpital Notre-Dame Hospital (Hearst) TELEDERM WOUND REFERRAL FORM

Telemedicine Department
Phone: 705-372-2970
Fax to: 705-372-2974

Urgency of Referral:

☐ 1-2 weeks

☐ Within 1 month

PLEASE PRINT CLEARLY ORAFFIX LABEL WITH COMPLETE INFORMATION

Patient name (last, First): _____

Address: _____

Telephone No.: _____

DOB (DD/MM/YYYY): _____ Sex: F M

Health Card No.: _____ VC: _____

Referring Physician: (print) _____
Signature: _____
Date: _____

Referral Note:

Chief Complaint:

Clinical History Relevant to Chief complaint (Enter questions, comments, thoughts or other relevant information. Be as detailed as possible.):

History of Present Illness:

Symptoms (for ulcers note: amount, color, odour of drainage, wound measurement size and depth include if there is any tunnelling, note wound bed appearance.):

Type of Skin Wound:

☐ Abrasion	☐ Blunt Injury	☐ Bruises	☐ Burn
☐ Contusion	☐ Cut	☐ Incision	☐ Insect bite
☐ Laceration	☐ Lesion	☐ Puncture	☐ Ulcer

Current treatment:

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Treatment /Medication tried for this condition:

Response to treatment	☐ Improved	☐ Worsened	☐ No Change

Medical History

Does the Patient have any of these conditions? (Select all that apply):

☐ Autoimmune disorders ☐ Circulatory problems ☐ Long term use of steroids
☐ Neurologic Conditions ☐ Vasculitis

Other conditions affecting healing

☐ Physiologic factors ☐ Functional factors ☐ Psychosocial factors
☐ Ehical considerations

Allergies (medication and/or Environmental):

What is the patient's nutritional intake?

☐ 1500 Calorie ☐ Diabetic ☐ High Protein ☐ Low Calorie
☐ Low Cholesterol ☐ Normal ☐ Supplemental

Current Medications (please attach list):

Is the patient incontinent of urine?

☐ Yes ___Times per day ☐ No

Is the patient incontinent of feces?

☐ Yes ___Times per day ☐ No

Does the patient have any of the following illnesses? (select all that apply)

☐ Dementia ☐ Depression ☐ Terminal Illness

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What is the patient's mobility level?

☐ Ambulatory ☐ Bed only ☐ Chair with assist ☐ Partially ambulatory

Vital Signs:

_____ Temp _____ Pulse _____ Resp _____BP _____ 02 Sat

Labs ordered:

☐ None ☐ Basic Metabolic labs ☐ CBC ☐ Chem 7
☐ Labs attached to this consult request ☐ Other tests ☐ Urinalysis ☐ Blood Culture
☐ Wound Culture

Diagnostic Imaging ordered:

☐ None ☐ Ultrasound ☐ X-ray ☐ Vascular Studies

Please Fax completed form to: 705-372-2974 or call to arrange appointment at: 705-372-2970.