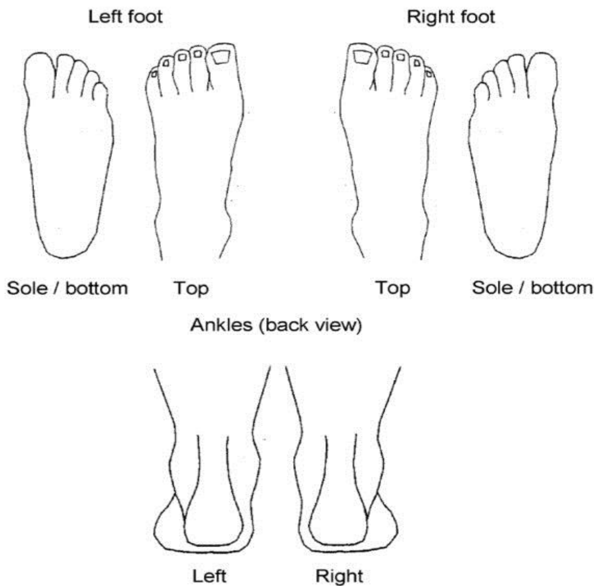
Ontario Local Health Integration Network / Réseau local d'intégration des services de santé

Diabetic Foot Ulcer Referral Form

Southwest Regional Wound Care Program

Patient Details

Name:	
Address:	GP/NP: Billing Number:
DOB:	Fax #:
Contact Number:	E-mail:



Please mark wound location.
Wound Details (e.g. previous treatment, dressings)

Duration of Ulcer:	Hgb A1c:
Depth of Ulcer: ☐ Superficial ☐ Partial Thickness ☐ Full Thickness ☐ Bone Involvement	
Is the ulcer clinically infected? ☐ Yes ☐ No	
Diabetic Foot Ulcer Risk Stratification & Referral Algorithm Score: ☐ 0 ☐ 1 ☐ 2a ☐ 2b ☐ 3a ☐ 3b	
Has offloading been provided? ☐ Yes ☐ No If yes, please indicate type: ☐ Total Contact Casting ☐ Removable Cast Walker ☐ Custom Orthotics	

***Please attach Cumulative Patient Profile (CPP) and send with referral

Signature: ______________________________ Date: ________________________