Ontario

South West Regional Wound Care Program

EPIDERMOLYSIS BULLOSA CLINIC: Pre-appointment preparation

SKIN

Blistering: ☐ better ☐ worse ☐ same

Where are the skin areas that you are most concerned about?

_____

_____

_____

_____

_____

Discharge/smell from wounds? N ☐ Y ☐

If yes, where? _____

_____

_____

_____

_____

Check and describe any problems you (your child) have (has) been experiencing:

Problem		Comments	Problem		Comments
Feeding problems:	N ☐ Y ☐		Mood:	N ☐ Y ☐	
G-tube problems:	N ☐ Y ☐		Sleeping Problems:	N ☐ Y ☐	
Vomiting:	N ☐ Y ☐		Pain:	N ☐ Y ☐	
Constipation:	N ☐ Y ☐		Itch:	N ☐ Y ☐	
Dental Problems:	N ☐ Y ☐		Walking/ Moving:	N ☐ Y ☐	
Eye Problems:	N ☐ Y ☐		Other:	N ☐ Y ☐	
School Problems:	N ☐ Y ☐		Other:	N ☐ Y ☐	

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List all of you current medications, including vitamins and over-the counter medications. Please indicate with a check mark (✓) if you need any prescriptions renewed today.

Medication	Dose	Any Problems with this Medication?	Need Medication Renewal
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Services

Service	Last Seen	Plan	Service	Last Seen	Plan
Gastroenterology			Pain Team		
Hematology			Cardiology		
Ophthalmology			Occupational/ Physiotherapy		
Dentistry			Social Worker		
Plastic Surgery			Other		
Other			Other		

Please write down any questions or concerns you would like to discuss today with your health care team: