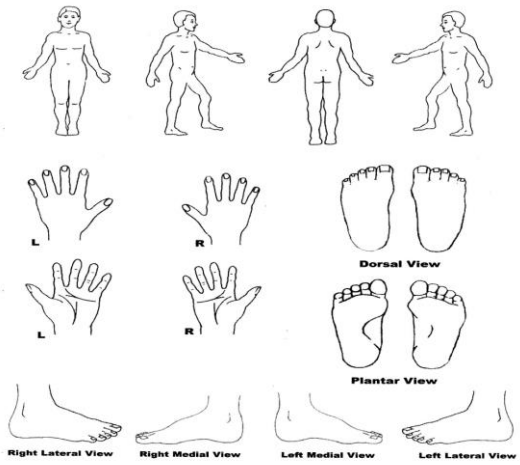
Virtual Wound Consult Referral Form

Patient Details	Requester Details
Patient Name:	Name:
HCN/BRN:	Organization:
Address:	Role/Title:
	Phone number:
DOB:	E-mail:
Contact Number:	



Reason for wound consult:

Please mark wound location on diagram below

Wound type: ☐ Pressure Ulcer ☐ Venous leg ulcer ☐ Arterial ulcer ☐ Skin Tear ☐ Surgical ☐ Diabetic foot ulcer ☐ Other:_____

☐ Verbal or Written Consent for this referral has been given by patient or Substitute Decision Maker

Signature: _____ Date: _____

Please fax to: 1-855-223-2847

Ontario