

WOUND CLINIC REFERRAL

Wound Care Nurse

Fax: 867-4428

Date: _____

Urgent

Elective

Referred By: _____

Phone: _____

Fax: _____

Patient has history of:

Previous leg or pressure ulcers _____ Diabetic _____ PVD _____ Smoker _____

Other: _____

Reason for Consult

Signature: _____

Wound Care Consultant: _____ Date: _____