WHCOR29

Western Health

Chronic Wound Service

Referral Form

Fax referral to 8345 0777

Hospital UR#.....

Name: .....

Address: .....

Suburb: .....

Postcode: ..... **Telephone:** .....

DOB:_____/_____/_____**Marital Status:** .....

Email Contact:

Referrers Name: ..... Position: .....Tel / Page .....

Referring Hospital / Agency / Clinic: ..... Unit: .....Ward:.....

GP Name: ..... Tel: .....

Clinic Name: ..... Fax: .....

Address: ..... Mobile: .....

Contact Person/Next of Kin:..... Tel: .....

Address: ..... Work: .....

Relationship: ..... Mobile: .....

Has the patient consented to this Referral: ☐ Yes ☐ No

Interpreter Required: ☐ Yes ☐ No Language: .....

Reason for Referral: (Include initial cause, duration, treatments used, any other relevant information)

☐ Wound present **> 4weeks** ☐ complex/complicated wound

(State details): .....

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Clinical Investigation Results attached (please tick):

☐ Blood tests ☐ X-ray ☐ Wound swab ☐ Wound biopsy ☐ Duplex scan

☐ Angiogram ☐ MRI ☐ Bone scan ☐ Other (state):

Relevant Medical/Surgical History: .....

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❒**Please attach medication list**

WHCOR29

Case Manager: (if Relevant): ..... Tel: .....

Agency: ..... Mobile: .....

Contact Person for Appointments: ..... Tel: .....

Address: ..... Work: .....

Relationship: ..... Mobile: .....

Any factors impacting on ability to attend a clinic appointment:

☐ Limited mobility ☐ Frail ☐ Unable to tolerate long consultations ☐ Hoist transfer only ☐ Transport issues

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Other (state): .....

Carer Availability	**Carer Relationship**	**Living Arrangements**	**Accommodation**
☐ No Carer	☐ Spouse/Partner	☐ Lives Alone	☐ Private (own/rent/purchase)
☐ Co-resident Carer	☐ Parent	☐ Lives with Family	☐ Outreach
☐ Non Resident Carer	☐ Child	☐ Lives with Others	☐ Supported Community
	☐ Child-in-law	☐ Not stated	☐ Residential Aged Care
	☐ Other Relative		☐ Residential Care Facility (not aged)
	☐ Friend/Neighbour		☐ Short Term Crisis/Emergency
	☐ Foster Carer		☐ Other Accommodation

Country of Birth:

Aboriginal or Torres Strait Islander ☐ Yes ☐ No

Medicare No:

Pension No:

DVA No: (if applicable)

TAC ☐ Yes ☐ No Claim Number:

Workcover ☐ Yes ☐ No Claim Number: