part of the Vancouver Coastal Health Authority

BRENDA AND DAVID MCLEAN INTEGRATED SPINE CLINIC

SPINAL CORD IMPAIRMENT WOUND CLINIC
REFERRAL FORM

Clients Name: _____
DOB: _____
Address: _____
Daytime Ph #: _____
Alt. Ph # or email: _____
PHN: _____
MRN: _____
Pixalere #: _____
WCB/ICBC Claim #: _____

2nd Floor, 818 West 10th Avenue
Vancouver, B.C. V5Z 1M9

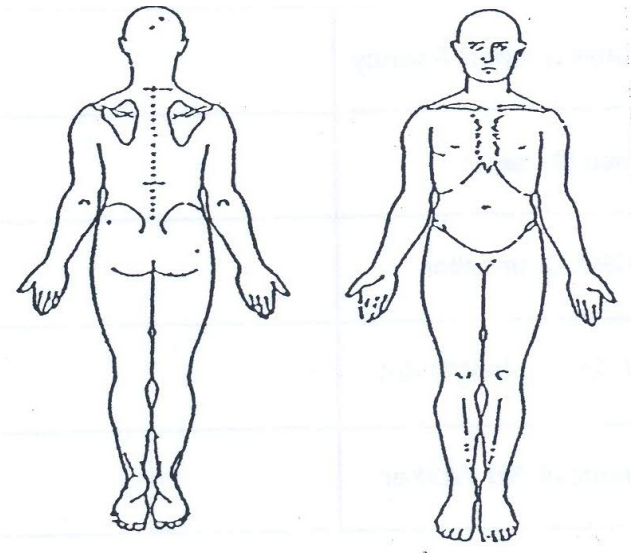
Telephone: 604-875-4992
Fax #: 604-875-5072

Referred by: _____ Contact Ph#: _____

Primary Physician Contact #: _____ Fax #: _____

SCI Injury Level: _____ Year: _____ Cause: _____

Referral Reason: ☐ Surgical Assessment ☐ Surgical Debridement ☐ Wound Assessment
☐ Nutritional Assessment ☐ Seating Assessment ☐ Other: _____



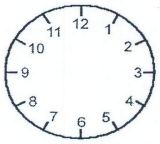
Wound #1 location: _____

Size: L:_____ W:_____ D:_____

Etiology:_____

Undermining: ☐ Yes ☐ No

(indicate direction and depth on clock face)



Comments:

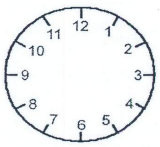
Wound #2 location: _____

Size: L:_____ W:_____ D:_____

Etiology:_____

Undermining: ☐ Yes ☐ No

(indicate direction and depth on clock face)



Comments:

Current Wound care (including frequency of dressing changes): _____

_____

Wound Care done by: ☐ Community nurse ☐ Client/Caregiver ☐ Clinic

Previous surgeries: _____

Infection status: ☐ MRSA ☐ VRE ☐ Hep C ☐ C-Diff ☐ Other:_____

History of aggressive behaviour: YES ☐ NO ☐ Comments: _____

Concurrent Dx: ☐ Diabetes ☐ Brain Injury ☐ Edema *(location/management)*: _____

☐ Respiratory *(specify)*: _____ ☐ Cardiac *(specify)*:_____

☐ Smoking/Substance abuse Hx: _____ Estimated body weight: _____

Client:_____ PHN:_____

Medications:_____

_____

_____

Allergies: _____

Tests: *(please attach most recent results)*

☐ albumin ☐ prealbumin ☐ CBC ☐ wbc scan ☐ CT scan ☐ bone x-ray ☐ ESR ☐ CRP

Bladder management: _____ Last urology consult: _____

Bowel management: _____

Transfer method:

☐ Independent ☐ 1 person assist ☐ 2 person assist ☐ Mechanical lift

Equipment:

Wheelchair: ☐ power ☐ manual

Requires: ☐ Translator/Language: _____ ☐ Caregiver will accompany

Funding Source: ☐ MEIA ☐ WSBCC ☐ ICBC ☐ NIHB ☐ Victim's Assistance ☐ Self

Additional Comments:

_____

_____

_____

Community Contacts:

Practitioner	Name	Phone	Fax
Case Manager			
Family Physician			
Home Care Nurse			
Physiotherapist			
Occupational Therapist			
Other			

Please include any recent lab work, diagnostics, or consults *(Physiatry, OT, PT, etc)* when faxing referral forms. Incomplete referrals will not be processed.

Signature: _____ Date: _____