Government of **Western Australia**
North Metropolitan Health Service

Sir Charles Gairdner Hospital
Referral to: FOOT & LEG ULCER CLINIC

DATE

CLIENT DETAILS *(use patient sticker if available)*

Given Names:	Surname:	
Date of Birth:		
Address:		Postcode:
Phone Home:	Work:	Mobile:
Hospital Unit Medical Record Number (if known):		
Medicare Number:	expiry date:	

MEDICAL HISTORY

☐T1DM ☐T2DM ☐PAD ☐IHD ☐CVA ☐CRF ☐Dialysis ☐Peripheral Neuropathy
Any known allergies:
Current medication:
Height: Weight: BMI:

REASON FOR REFERRAL

MAIN CONCERN ☐Leg Ulcer ☐Foot Ulcer (If diabetic please refer to MDFU)

DURATION ☐<4 weeks ☐4 – 12 weeks ☐>3 months ☐**Recurrent Ulcer**

Brief description of main concern:_____

_____

_____

NEUROVASCULAR ASSESSMENT (tick if palpable)

Right DP☐ PT☐ ABI/TP= **Left** DP☐ PT☐ ABI/TP=

CURRENT TREATMENT

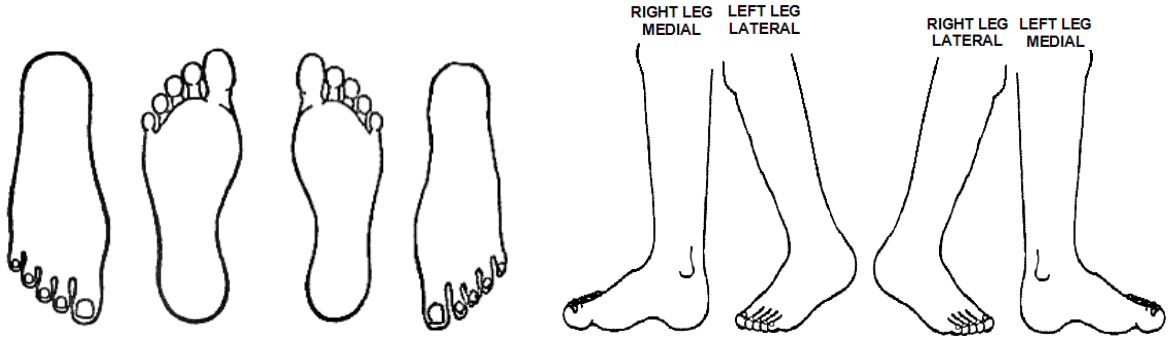
Wound Care_____

Antibiotics_____

Offloading_____

Compression/stockings_____

Please indicate areas of concern



MEDICAL/SURGICAL SPECIALISTS

(Name, specialty, public/private, current involvement, date of last & next appointment)

REFERRAL SOURCE DETAILS	**GENERAL PRACTITIONER**
Name:	GP:
	Provider #:
Title/Designation:	Practice:
Practice:	
Phone Number:	Phone Number:
Fax:	Fax:

Fax to Central Referrals 1300 365 056

Any queries or for urgent referrals (need to be seen in less than seven days) – please contact SCGH Foot & Leg Ulcer Clinic
Phone: 6457 3266 Fax: 6457 1899

Please Attach All Relevant Investigations, Reports & Results

REFERRAL ELIGIBILITY

Outpatient with complex medical needs presenting with either:

- Non-diabetic foot ulcer, duration > 4 weeks
- Leg ulcer, duration > 3 months

which is static or deteriorating OR not responding to best practice

Reason for referral:

a. Unclear aetiology of ulcer
b. Suspected or confirmed osteomyelitis
c. Suspected or confirmed PAD including dry stable necrosis

For urgent referrals – patients with acute symptoms such as ascending cellulitis please refer direct to the closest emergency department

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