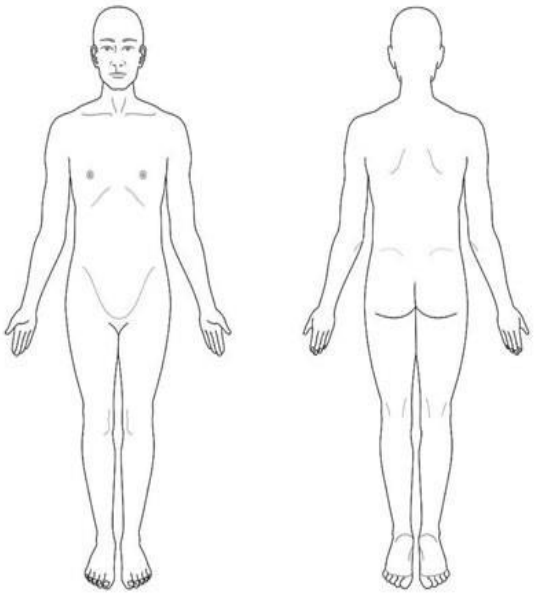
Wound Referral Form

Name:	**Address:**	**Date:**
DOB:	**Allergies:**	**Doctor:**
Medicare Number:		**DVA Number: (If applicable)**

Type of consultation: On-site (Min of 5 referrals required) ☐ Telehealth ☐

Relevant Medical History:

Palliative Care: Yes ☐ No ☐



Location of wound: _____
(please also mark on diagram)

Skin Tear:
Category 1a ☐ 1b ☐ 2a ☐ 2b ☐ 3 ☐

Pressure Injury:
Stage I ☐ Stage II ☐ Stage III ☐
Stage IV ☐ Suspected deep tissue ☐
Unstageable ☐

Ulcer:
Diabetic ☐ Mixed ☐ Venous ☐ Arterial ☐ Unknown ☐

Skin Cancer ☐ Abrasion ☐ Blister ☐

Surgical ☐ Laceration ☐ Burn ☐

IAD ☐ Other

Surrounding skin: Inflamed (heat/redness/swelling) ☐ Friable ☐ Macerated ☐ Dry ☐

Length:	**Depth:**	**Width:**
Wound colour: Pink ☐ Yellow ☐ Black ☐ Green ☐ Red ☐	**Pedal pulse:** Yes ☐ No ☐ Temperature: _____	**Pain:** During procedure ☐ Intermittent ☐ Constant ☐
Exudate amount: Heavy ☐ Low ☐ Moderate ☐ Nil ☐	**Wound odor:** Yes ☐ No ☐	**Wound edge:** Level ☐ Rolled ☐ Raised ☐ Undermined ☐

Exudate type:	**Surrounding edges:**
Nil exudate - ☐	Intact - ☐
Clear - No colour ☐	Excoriated - ☐
Serous - (Yellow) ☐	Dry Scaling - ☐
Haemoserous - (Red/Yellow) ☐	Bruised - ☐
Purulent - (Green/Brown) ☐	Fragile - ☐
Tissue:	Macerated - ☐ (Softening and/or breakdown of the skin)
Epithilial (Pink or pearly White) ☐	Odemeatous - ☐ (Excessive fluid may indicate infection/injury)
Granulating (Red and moist) ☐	Erythema - ☐ (Redness may indidcate infection)
Slough (yellow, brown or grey) ☐	**Infection** yes ☐ No ☐
Necrotic Hard, dry and black) ☐	
Hyper granulating (Red, uneven or granular) ☐	

Current cleansing agent:	**Current primary dressing:**	**Current secondary dressing:**

Current bandaging/retention dressing:	**List any previous treatments attempted?**
Current frequency:	

I have attached the patient's medical history and medication chart	Yes		No		
I have sent clear current colour photos of the wound with the patient's details	Yes		No		
Has the patient/NOK provided consent?	Yes		No		

Referring person signature:	Print name:
Manager/Clinical Managers Name:	Email: Phone: (Invoice will be sent to this email)

Please email completed referral form to woundconsult@reliancehealthservices.com