Vancouver Coastal Health
Promoting wellness. Ensuring care.

BRENDA AND DAVID MCLEAN INTEGRATED SPINE CLINIC

SPINAL CORD IMPAIRMENT WOUND CLINIC REFERRAL

2nd Floor, 818 West 10th Avenue
Vancouver, BC V5Z 1M9

Telephone: 604-875-4992 option 1
Fax: 604-875-5072

Information for Referring Physicians and Clinicians

All referrals are promptly triaged and assigned an appropriate specialist in the clinic. It is VERY IMPORTANT that you provide us with the correct and complete information on the referral form.

- ➔ **Incomplete referrals will be returned to the referrer and this will result in delays for your patient.**

Mandatory Requirements:

- **Completed SCI Wound Clinic Referral Form**
  - **Please print clearly (as the fax machine can blur writing over time)**
- **A <u>typed</u> summary including the following (handwritten will not be accepted):**
  - **History of the wound**
  - **How long has the wound been present**
  - **How did the wound start initially**
  - **Suspected etiology**
- **Relevant medical reports and consultations**
  - **Doctors, PT, OT, ect**
- **Medication list and Allergies**
- **Any relevant and recent lab work, cultures or biopsies or diagnostic test results**

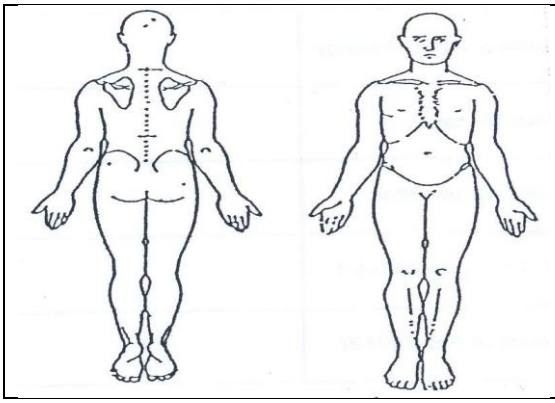
Please fax complete referrals to <u>604-875-5072</u>

SPINAL CORD IMPAIRMENT WOUND CLINIC REFERRAL FORM

BRENDA AND DAVID MCLEAN INTEGRATED SPINE CLINIC **2nd Floor, 818 West 10th Avenue Vancouver, B.C. V5Z 1M9** **PH: 604-875-4992 (option 1)** **FAX: 604-875-5072**	Clients Name: _____ DOB: _____ PHN: _____ Best PH: _____ MRN: _____ Pixalere : _____

REFERRED BY: _____ Title: _____

PH: _____ FAX: _____



Referral Reason:

- ☐ Surgical Assessment
- ☐ Surgical Debridement
- ☐ Wound Assessment
- ☐ Seating & Surfaces Assessment
- ☐ Other: _____

Wound #1 location: _____ Size: L: _____ W: _____ D: _____

Undermining (direction(s) & depth(s): _____

Wound Base description: _____

Wound Edges: _____ Exudate: _____

Wound #2 location: _____ Size: L: _____ W: _____ D: _____

Undermining (direction(s) & depth(s):_____

Wound Base description: _____

Wound Edges: _____ Exudate: _____

Comments:_____

_____

_____

Current Wound Care Plan & Frequency:

_____

_____

Care provided by: ☐ Home Health Nurse ☐ Ambulatory Clinic ☐ Caregiver ☐ Client/Self

Previous surgeries & date if known:

_____

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

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

Notable Co-morbidities/ Diagnoses/ drug and alcohol use/ smoker (list below in chart)

SCI Injury Level: _____ Year of injury: _____ Cause: _____

Height: _____ Weight: _____

Transfer method: ☐ Independent ☐ 1 person assist ☐ 2 person assist ☐ Mechanical lift

Wheelchair: ☐ Power ☐ Manual Comment: _____

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

Community Contacts:

Practitioner	**Name**	**Phone**	**Fax**
Family Physician			
Community Nurse			
Physiotherapist			
Occupational Therapist			
Case Manager			
Other			

Complete to the best of your knowledge