



MRN: _____ D.O.B: _____
 Surname: _____
 First Name: _____
 Address: _____
 Phone: _____ Sex: Male/Female
 LMO: _____

PATIENT DETAILS

Illawarra Leg Ulcer Clinic Referral Form

REFERRAL CRITERIA

- Ulcer wound
- Located on lower leg
- Non-diabetic foot wound
- Previously seen by GP/Community Nurse
- Not already under the care of a vascular surgeon
- Patient resides in an area covered by Wollongong, Kiama or Shellharbour Councils

MEDICAL HISTORY

ULCER HISTORY

Causation: _____

 Duration: _____

PREVIOUS INVESTIGATIONS

- (relating to wound)
- Angiogram
 - Ankle Brachial Index
 - Wound Swab/Scraping
 - Biopsy
 - Blood Tests

<input type="checkbox"/> UEC	<input type="checkbox"/> Full Blood Count
<input type="checkbox"/> BSL	<input type="checkbox"/> Serum Albumin
	<input type="checkbox"/> Thyroid Function
 - Venous Duplex Scan
 - Arterial Duplex Scan
 - Other

NB attach copy of the results from the most recent pathology screen and/or other relevant tests

PREVIOUS TREATMENTS

(incl. Dressings, surgery etc) _____

FACTORS THAT MAY DELAY HEALING:

- Diabetes
- Immobility
- Medications eg corticosteroids (see Medication List Attached)
- Allergies _____
- Poor nutritional status
- Anaemia
- Social Isolation

DATE: _____
 Usual GP: _____
 Community Health Centre/Nurse: _____

- Non-compliance
- Alcohol
- Other _____
- NB attach most recent medication list
- Ex-Smoker
- Smoker

COMMENTS:

PATIENT CONSENT:

- The purpose of this referral to the Illawarra Leg Ulcer Clinic has been explained to me.
 - I give consent to this referring party to provide relevant personal details and medical history to the Clinic and my usual GP.
 - I understand that I will be looked after by more than one community nurse and GP over my series of visits to the Clinic.
 - I understand that it is necessary for these health professionals to collect information essential to the treatment and on-going care of my leg ulcer and the evaluation of the Clinic and give consent to this collection (including digital photo of ulcer)
 - I understand that only appropriate personnel involved in this Clinic and this referral will have access to these records.
 - I consent for this information collected to be communicated back to this referring party, my community nurse and my usual GP.
- For further information regarding this consent please contact Monique O'Hara at IDGP on 4226 7052.
- Signed: _____ Date: _____

REFERRAL CHECKLIST:

- Establish that patient meets Clinic Criteria
- Attach/Obtain recent blood result
- Attach most recent Medication List
- Attach any other relevant results.
- Obtain patient consent
- Arrange first appointment on **4223 8201**.

REFERRED BY:

- GP
- Other Allied Health
- Community Health Nurse

Name: _____
 Address/Centre _____

 Phone: _____
 Signed: _____ Date _____

I agree to have ILUC GPs make appropriate referrals for my patient on my behalf