WCHH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2

Tel: 416-323-6407 Fax: 416-323-6215

WOUND CARE CENTRE REFERRAL FORM

URGENCY: ❑ Routine ❑ Semi-Urgent ❑ Urgent

REFERRAL DATE: ____/____/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:_____ HCN:_____

Name:_____

Sex:_____ Date of Birth:____/____/_____
DD / MM / YYYY

Address:_____

Telephone:_____ Alternate #:_____

SPECIFIC PHYSICIAN: ☐ No (First available) ☐ Yes: Dr. _____

ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ _____

Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay

Language spoken: Interpreter required: ☐ Yes ☐ No

REFERRING PROVIDER INFORMATION

Name:

Address:

Telephone:

Fax:

Billing #: _____

Signature: _____

☐ Referring Provider is not the Primary Care Provider

Primary Care Provider Name: _____ Phone:_____ Fax:_____

REASON FOR REFERRAL

Details of wound	**Reason for Consult** *(if urgent please specify why)*	**Please attach all relevant results/reports:**
Location: Duration: Size:		☐ Bloodwork (CBC) ☐ Pathology reports ☐ Consultation reports ☐ Doppler reports ☐ Imaging reports

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):