



WOMEN'S COLLEGE HOSPITAL 76 Grenville Street
Toronto, Ontario
Healthcare | REVOLUTIONIZED 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:		<input type="checkbox"/> Bloodwork (CBC)
Duration:		<input type="checkbox"/> Pathology reports
Size:		<input type="checkbox"/> Consultation reports
		<input type="checkbox"/> Doppler reports
		<input type="checkbox"/> Imaging reports

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):

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