

North Bay Regional Health Centre

Wound Care Clinic Referral

<input type="checkbox"/> Referral to Dr. Gong Wound Care Clinic Complete and Fax to Dr. Gong's office 705-476-6543	<input type="checkbox"/> Referral for Wound Care Nurses at NBRHC Complete and Fax to ACU 705-495-2419
<ul style="list-style-type: none"> This form must be completed for referral to the Wound Care Clinic Wound Care Clinic is on alternative Wednesdays. Dr. Gong triages all referrals. Any patients requiring urgent treatment need to proceed to the Emergency Department. 	<ul style="list-style-type: none"> For wound care referrals that require a wound care specialist but no physician intervention Patients will be triaged by wound care nurses and booked appropriately

Patient Information		
Last Name:	First Name:	DOB:
Health Card #:	Gender:	
Address:	Phone # (preferred):	
	Phone # (Alternative):	
Physician Information		
Referring Physician:	Phone #:	
Billing #:	Fax#:	
Referral Date:	Family Physician:	
Referring Physician Signature:		

Wound Etiology (Do not send referrals for pilonidal cysts, skin biopsies, ingrown toenails, or anal fistulas)	
<input type="checkbox"/> Pressure Ulcer	<input type="checkbox"/> Venous Leg Ulcer
<input type="checkbox"/> Leg Ulcer	<input type="checkbox"/> Diabetic Foot Ulcer
<input type="checkbox"/> Surgical Site (referral from primary surgeon)	<input type="checkbox"/> Burns
<input type="checkbox"/> Trauma	<input type="checkbox"/> Other _____
Location, Size of Wound, Current treatment	

Patient Mobility Information		
<input type="checkbox"/> Arriving via ambulance?		
Is patient:		
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Able to transfer	<input type="checkbox"/> Require lift

Relevant Medical History, Medications, and Diagnostic Imaging (please attach)