Communication with Referring Physician/NP: LOWER EXTREMITY WOUND PATHWAY

ATTN:

RE: Patient Name:

Patient contact info:

Your patient was assessed by Regional Home Care Team personnel as follows:

Date: _____ Location: _____

Assessed by: _____

☐ ABI ☐ TBI _____ Other investigation: _____

REGIONAL HOME CARE TEAM REQUESTING:

Clinical follow-up:	Referral to specialist ☐ re. foot deformities: _____ ☐ re. surgical consult: _____ ☐ re. non-healing wound:_____ ☐ other:

TREATMENT INITIATED ACCORDING TO WOUND PROTOCOL (NO FOLLOW UP REQUIRED)

Based on wound characteristics and discussion with the patient, treatment was initiated as follows. You will be notified of any subsequent changes in your patient's condition or treatment.

The goal of treatment: ☐ Healing ☐ Maintenance

ETIOLOGY	**TREATMENT INITIATED**
VENOUS	☐ Compression _____ ☐ Wound dressing _____ ☐ Patient education re self care ☐ Wound swab ☐ Other:
NEUROPATHIC/ ISCHEMIC/ DIABETIC	☐ Wound dressing _____ ☐ Fit for offloading device ☐ Patient education re self care ☐ Wound swab ☐ Other

Clinician NAME PHONE NUMBER DATE SIGNATURE