Communication from Home Care Team to Referring Physician/RN(NP)
Saskatchewan Lower Extremity Wound Pathway

Attention: _____

Fax #: _____

Reason for communication:

☐ **Information only**

☐ **Follow-up requested**

Patient Name: _____

Address: _____

DOB: _____ HSN: _____

Age: _____ Treaty: _____

Phone(h) _____ (w) _____

Your patient was assessed by Home Care Team personnel on - date: _____

☐ ABPI Right: _____ Left: _____

☐ TBPI Right: _____ Left: _____

☐ Wound Swab taken – date: _____

COMMENTS:

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

Based on wound characteristics and discussion with the patient, treatment was initiated following the Saskatchewan LEWP best practice protocols. You will be notified of any subsequent changes in your patient's condition or treatment.

The goal of treatment: ☐ Healable ☐ Non-Healable ☐ Maintenance

	PROTOCOL	**Treatment initiated**
☐	VENOUS STASIS ULCER	☐ Compression _____ ☐ Wound dressing _____ ☐ Other: _____
☐	DIABETIC FOOT ULCER	☐ Compression _____ ☐ Wound dressing _____ ☐ Other: _____
☐	ARTERIAL/ NON-HEALABLE WOUND	☐ Wound dressing _____ ☐ Other: _____
COMMENTS:		

HOME CARE TEAM REQUESTING

Referral to specialist:	**Comments/ follow-up requested:**
☐ Surgical consult: _____	
☐ Foot deformities: _____	
☐ Offloading Device: _____	
☐ Other: _____	

Clinician Name: _____ **Date:** _____

Phone Number: _____ **Signature:** _____