WINDSOR TEAM CARE CENTRE

150-2475 McDougall St. Windsor ON. N8X 3N9
Ph: (519) 250-5524
www.windsortcc.ca

Southwest Ontario Aboriginal Health Access Centre

1405 Tecumseh Rd W, Windsor, ON. N9B 1T7
Ph : (519) 916-1755

CLEAR

Lower Limb Wound Prevention & Treatment Clinic

Patient Information		**Date of Referral:**	
Name: (First, Last)		Address:	
Date of Birth:		OHIP #:	
Phone: (H) (M)		Email:	
Language:	☑ English ☐ French ☐ Other: ________________		
Sex:	☐ Male ☐ Female ☐ Prefer not to answer ☐ Gender Identity: __________		
Identifies as:	☐ First Nation ☐ Metis ☐ Inuit ☐ Non-Indigenous		
Patient provided verbal consent to participate in Team Care? ☐ Yes ☑ No		Patient provided verbal consent for Team Care to leave a confidential voicemail? ☐ Yes ☐ No	

****Please note: to be eligible for this program patient MUST be diagnosed with Diabetes, Peripheral Artery Disease and/or Active Lower Limb Wound****

Services Requested - *Please identify requested services by checking the boxes.*

Triage Level:

☐ Non-Critical ☐ Critical**

*****Please send patients who are medically unstable or have gotten worse in the past 24hrs to the emergency department.*****

Primary Wound Detail:

Type of wound:

☐ Venous ☐ Arterial ☐ Diabetic ☐ Traumatic
☐ Maintenance ☐ Healable ☐ Non-Healable
☐ Other: ____

Location of Wound: ______________________________

Size of Wound (cm): ______________________________

Has the wound been non-healing for more than 2 weeks?
☐ Yes ☐ No ☐ Unknown

Evidence of Infection?
☐ Yes ☐ No ☐ Unknown

Diagnosed Conditions:

☐ End Stage Renal Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ History of Foot Ulcer
☐ Peripheral Artery Disease (PAD)
☐ Peripheral Neuropathy
☐ Type 1 or Type 2 Diabetes

****Please attach patient profile and blood work (if available) along with referral form****

Reason for Referral:

☐ Multiple hospital admission, clinic and/or ED visits
☐ Resides in a high priority neighbourhood (N8H, N8X, N8Y, N9A, N9B, N9C, N9Y)
☐ Experiencing homelessness or living in social housing
☐ Other social needs (access to transportation or no OHIP, etc.)

Additional Information:

Provider Stamp:

(Check off site of referral origin)

☐ ED or Hospital d/c
☐ LHIN or Diabetes Wellness or Street Health (weCHC)
☐ Urgent Care Clinic
☐ Homeless/Shelter Health or H4
☐ Welcome Centre

CENTRAL INTAKE - Fx: (519) 250-3894