**Blue Care Wound Clinic *Referral Form***

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| **Referred Client Details** |
| Surname: |  |
| Given Names: |  |
| Date of Birth: |  |
| Gender: |  | To be funded by :🞏 CHSP🞏 QCC🞏 HCP🞏 Full Fee |
| Address: |  |
| Phone: |  |
| Medicare Number: |  |
| DVA Number: |  |
| **External Referrer Details** |
| Date: | External Referrer Name: *e.g. hospital or GP Practice name* | External Referrer Contact Person & Details:  |
| **Wound Details** |
|  Diabetic FootPressure InjuryLeg UlcerOtherSkin TearMalignancySurgical**Wound History:**Duration of wound days/weeks/months Initiating Event/Date Occurred Recent Investigations *(biopsy, x-ray, blood test, ABPI, swab)*  |
| **Treatment History & Plan -*****Please attach prescribed treatment plan if applicable*** |
| *eg. wound care provided to date and the service provider details..* |

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| **Past Medical & Surgical History –*please provide a health summary*** |
| **Conditions** | **Yes** | **No** | **Provide dates of treatment/diagnosis below** |
| Hypertension |  |  |  |
| DVT |  |  |  |
| Diabetes Mellitus |  |  | Type 1 or 2 |
| Varicose Veins |  |  |  |
| Autoimmune disorders |  |  |  |
| Malignancy |  |  | Location & type  |
| **Current Medications – *please attach list of medications*** |
| If the client is seeking funded services, please clearly specify below by ticking the services the client will require to expedite the MAC process.🞏Nursing 🞏 Podiatry 🞏Dietetics 🞏Transport |

**Please complete form and email to** communitycare@bluecare.org.au