SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE

Sud-Ouest

Wound Consult Request – Virtual

356 Oxford	Street \	Vest L	ondon,	ON No	6H 1T3
Telephone: 1	-800-81	1-514	6 Fax: 51	19-472	2-4045

Patient Information		
Surname		First Name
Home Address		
City		Postal Code
Health Card Number (HCN)	Version Code	Date of Birth (YYYY-Month-DD)
Gender Identity		Pronouns
Male Female Undifferentiated	Unknown	He/Him She/Her They/Them

Virtual consultation is available for all wound types and patients, in any care setting that meets the eligibility criteria. At times, further investigations may be requested by the South West Regional Wound Care Program (SWRWCP) to support appropriate treatment recommendations.

Regardless of eligibility, if the SWRWCP determines that the complexity of the wound or the patient condition requires an in-person assessment, virtual consultation will end and the referral source will be notified of alternate options for an in-person wound assessment.

Form Instructions

Please fax the completed form to the South West Regional Wound Care Program toll-free at 1-833-243-8532 or by direct line at 519-637-4864.

by direct line at 519-637-4	864.
Required Service – Sele	ct Only ONE (1)
Service	Eligibility Criteria
NSWOC/WCS/ET	 A Nurse Specialized in Wound, Ostomy and Continence (NSWOC) or a Wound Care Specialist (WCS) or an Enterostomal Therapy Nurse (ET) is not accessible.
	 Has a nurse, community paramedic, or competent informal caregiver available and willing to attend virtual assessment and implement wound care recommendations.
	 Has access to technology to allow for wound visualization, i.e. smart phone, computer, tablet.
	• Patient does not demonstrate untreated signs of spreading systemic infection. i.e. a fever of 38°C or higher, or chills; increased drainage or pus; increased redness to the skin around the wound; skin around the wound becomes warm or hot to the touch; increased swelling; worsening pain in or around the wound; a new or worsening odour.
Nurse Practitioner – Wound Care	Patients with complex wounds requiring medical oversight and/or prescriber authorization related to the wound.
	 Patients with wounds that are not healing despite best practices, requiring further medical evaluation or investigation to support wound healing.
	 Patients with recurrent wound-related infections or emergency department visits.
	Patients with wound recurrence within 6 months of wound closure.
	 Primary Care Provider requests for NP Wound Care specialized knowledge/ support.

Arterial Ulcer Diabetic Foot Ulcer Pressure Injury Skin Tear Surgical Venous Leg Ulcer Unknown Other Found(s) Location Found(Surname	First	Name		Health Card Number
Arterial Ulcer Diabetic Foot Ulcer Pressure Injury Skin Tear Surgical Venous Leg Ulcer Unknown Other Found(s) Location Wound Measurements (LxWxD) Onsent Disclaimer The patient, or substitute decision maker, has provided verbal or written consent for this referral. Yes No sefererer Details The referrer Name Role/Title Thone Number Fax Number Thank Address Stirty Postal Code	Reason for Consultat	ion			
Arterial Ulcer Diabetic Foot Ulcer Pressure Injury Skin Tear Surgical Venous Leg Ulcer Unknown Other Found(s) Location Found(lease provide a brief descrip	otion of the history of the preser	nting concern and/or reasor	n for consult request.	
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Wound Measurements (L x W x D) Onsent Disclaimer The patient, or substitute decision maker, has provided verbal or written consent for this referral. Yes No eferrer Details teferrer Name Role/Title Thone Number Fax Number Imail Address Roled Code Postal Code	Arterial Ulcer	Diabetic Foot Ulcer	Pressure Injury	Skin Tear	Surgical
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Referrer Signature Date Signed (YYYY-Month-DD)	R	eferrer Signature		Date Signed (YYYY-	Month-DD)

A follow-up assessment, as deemed appropriate by the SWRWCP, will be completed within 2-4 weeks of initial consultation. If wound condition deteriorates prior to the arranged follow-up, please contact the SWRWCP by emailing SWRWCP@hccontario.ca to arrange a timely follow-up.