HOME AND COMMUNITY CARE SUPPORT SERVICESERIE ST. CLAIR
SERVICES DE SOUTIEN A DOMICILE ET EN MILIEU
COMMUNAUTAIRE D'ÉRIÉ ST-CLAIR

Print

Medical Update Request Form - Wound

Physician / Health Care Provider: _____

HCCSS Caseload: _____ Frequency of Visits: _____

Fax completed form to: _____ _____
Agency **Fax Number**

Patient Name: _____ DOB (dd/mm/yy): _____ BRN: _____

Diagnosis: _____ Allergies: _____

Present Status (Completed by Nursing Service Provider):

Wound: ☐ New ☐ Healing ☐ Non-Healing ☐ Maintenance **Odour:** ☐ Present ☐ Absent

Infection: ☐ Suspected ☐ Present **Osteomylitis:** ☐ Present ☐ Absent

Infection Management: ☐ Parenteral ☐ Oral Antibiotics ☐ Antimicrobial Dressing

No. of Dressing Changes/Wk: _____ **Size:** _____ LxWxD (cm) **Pain (0-10):** _____

Location: _____ **ABPI:** Right: _____ Left: _____ **Date (dd/mm/yy):** _____

Exudate: ☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large **Type:** _____

Wound Bed: ☐ Granulation ☐ Slough ☐ Eschar ☐ Other: _____

Peri Wound Skin: ☐ Macerated ☐ Erythema ☐ Callous ☐ Dry and Intact ☐ Indurated ☐ Denuded
☐ Other: _____

Services Involved: ☐ ET (Name of ET): _____ ☐ Chiropodist ☐ Dietician ☐ Social Work
☐ Physiotherapy ☐ Occupational Therapy ☐ Other: _____

Other Information: _____

Current Treatment Concerns / Requests:

Request: ☐ Compression: _____ ☐ Offloading Device ☐ Antibiotics ☐ Vascular Studies
☐ Blood Work ☐ ABPI Results ☐ Bone Scan/WBC ☐ Other: _____

_____ _____
Signature Print Name / Designation / Title

_____ _____
Agency / Extension Date (dd/mm/yy)

Physician / Health Care Provider's Response / Orders: Specify wound etiology: _____

☐ Best practice/evidenced based practice (Wound care outside of evidenced based practice may not be eligible for HCCSS services. Treatment will be taught and service reduced when appropriate).

_____ _____
Signature Print Name / Designation / Title

_____ _____ _____
CPSO / CNO Reg. Number OHIP Billing Code [1] Date (dd/mm/yy)

Service Provider Use Only:

☐ Reviewed by Service Provider Initial: _____ Date (dd/mm/yy): _____

1 Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.