Champlain Diabetes Chiropody Program - Referral Form

Please Fax *Completed* Referral to **613-774-7241**

Tel: 613-783-7760 Toll free: 1-888-220-8010

All <u>incomplete</u> forms will be returned to the referring provider.

<u>Admission to services is not guaranteed.</u>

Our clinics provide services for diabetic foot ulcers and ingrown toenails with bacterial (not fungal) infections.

We *<u>do not</u>* provide routine foot care.

Referring Provider: _____ Phone Number: (_____) _____

Fax Number :(_____) _____ Request communication back? ☐ Yes ☐ No

Client Information:

Last Name: _____ First Name: _____

DOB: (YYYY)/(MM)/(DD)_____/_____/_____

Gender: ❑ Male ❑ Female ❑ Trans male ❑ Trans female ❑ Intersex ❑ Two-Spirit ❑ Please specify: _____

Phone: (_____)_____ Alternate Phone: (_____)_____

Address: _____

OHIP#_____ V.C._____ Primary Care Provider: _____

Language: ☐ English ☐ French ☐ Please Specify: _____ ☐ Interpreter required (Check box)

Client has: ☐ Type 1 Diabetes ☐ Type 2 Diabetes (Insulin, Oral and/or Diet) ☐ Pre Diabetes Client HbA1C:_____

IMPORTANT *Following fields are required to access services

* History of present illness: Attached ☐ N/A ☐ _____

* Relevant medical conditions: Attached ☐ N/A ☐ _____

* Allergies: Attached ☐ N/A ☐ _____

* Medications: Attached ☐ N/A ☐ _____

* Imaging/Lab results: Attached ☐ N/A ☐ _____

Referral for:

☐ <u>Foot ulcer</u>

☐ <u>Ingrown toenail with bacterial infection</u> (*Note to referring provider: **Please start antibiotics if appropriate**)

Has the client been referred to:

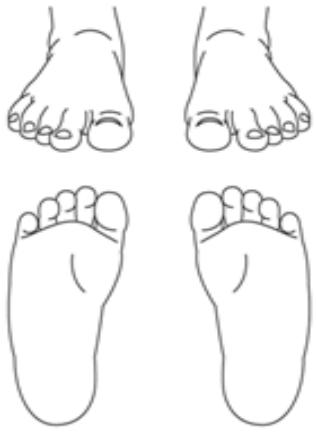
Yes ☐ No ☐ Home & Community Care (nursing care)

Yes ☐ No ☐ Diabetes Education Program

Yes ☐ No ☐ Vascular Diagnostic Centre

Yes ☐ No ☐ Infectious Disease Clinic

Specify ulcer location(s) on the foot diagram



Additional Comments:

_____

_____

_____

_____

_____

_____

_____