Champlain Rural 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.
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 (MM/DD/YYYY): _____/_____/_____
Gender: ❑ Male ❑ Female ❑ Trans male ❑ Trans female ❑ Intersex ❑ Two-Spirit ❑ Please specify: _____

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

Address: _____

OHIP#: _____ V.C._____ Family MD/NP: _____

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: _____
History of present illness: Attached ❑

_____

Relevant medical conditions: Attached ❑

_____

Allergies: Attached ❑ _____
Medications: Attached ❑ _____
Imaging/Lab results: Attached ❑ _____

Client has been referred to: ❑ Diabetes Education Program, ❑ Home and Community Care (nursing wound care),
❑ Infectious Disease Physician, ❑ Vascular Surgeon, ❑ Vascular Diagnostic Centre

Criteria for referral:

❑ **Diabetic Foot Ulcer** (With at least **one** of the following):
❑ Palpable pedal pulses
❑ ABI greater than 0.7 calculated from dorsalis pedis AND posterior tibial arteries _____
❑ Toe Brachial Index greater than 0.4 _____

For all clients with suspected peripheral arterial disease and foot ulcer(s), please arrange extremity arterial duplex scan with TBI measurements, and provide report if available.

Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____

Specify ulcer location(s) on the foot diagram