



**Sir Charles Gairdner Hospital**

**Referral to: MULTIDISCIPLINARY FOOT ULCER CLINIC**

**DATE**

**CLIENT DETAILS** *(use patient sticker if available)*

Given Names: Surname:

Date of Birth:

Address: Postcode:

Phone Home: Work: Mobile:

Hospital Unit Medical Record Number (if known):

Medicare Number: expiry date:

**MEDICAL HISTORY**

☐T1DM ☐T2DM ☐PAD ☐IHD ☐CRF ☐Dialysis Peripheral Neuropathy

Smoking status (current/past/never):

Diabetes duration (if applicable):

**Any known allergies:**

Current medication (attach medication list):

Prior imaging (attach results):

Height: Weight: BMI:

**REASON FOR REFERRAL**

☐Foot Ulcer ☐Suspected Charcot Foot ☐Other (please provide detail below)

☐Recurrent Ulcer

**Brief description of main concern:**

**DURATION** ☐<4 weeks ☐4 – 12 weeks ☐>3 months

**FOOT PULSES – tick if palpable**

**Right**  DP PT **Left** DP PT

**CURRENT TREATMENT**

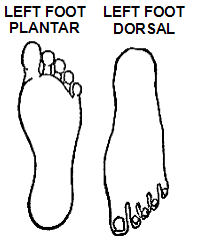
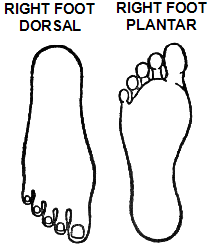
Wound Care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antibiotics\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Offloading\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate areas of concern on foot diagram:**



**MEDICAL/SURGICAL SPECIALISTS**

(Name, specialty, public/private, current involvement, date of last & next appointment)

**REFERRAL SOURCE DETAILS GENERAL PRACTITIONER**

Name: GP:

Provider #:

Title/Designation: Practice:

Practice:

Phone Number: Phone Number:

Fax: Fax:

**Fax to Central Referrals 1300 365 056**

**Please address any written referrals to the ‘Multidisciplinary Foot Ulcer Clinic’**

**For inter hospital transfers, please fax the referral directly to the Podiatry Department**

**Fax: 6457 1568**

**For any urgent referrals (need to be seen in less than seven days) – please contact the on-duty Vascular Registrar via switchboard.**

**All other queries can be directed to the SCGH Multidisciplinary Foot Ulcer Clinic Phone: 6457 3373 Fax: 6457 1568**

**Please Attach All Relevant Investigations, Reports & Results**

**REFERRAL ELIGIBILITY**

Outpatient with complex medical needs presenting with either:

* Foot ulcer, duration > 4 weeks
* Foot infection

which is static or deteriorating OR not responding to best practice

Reason for referral:

* 1. Unclear aetiology of ulcer
  2. Suspected or confirmed osteomyelitis
  3. Suspected or confirmed PAD including dry stable necrosis

**OR**

Suspected or confirmed active Charcot foot:

* hot, red swollen foot
* in the presence of peripheral neuropathy with
* minimal or no reported trauma / progressing deformity

**For urgent referrals – patients with acute symptoms such as ascending cellulitis please refer direct to the closest emergency department**