

**Lower Leg Assessment Clinic Referral Form**

<b>Date of Referral:</b>	
<b>Patient information</b> Full Name: PHN: DOB: Gender:	Address:  Phone Number: Alternate Phone Number: Email:
<b>Referring Provider:</b>	<b>Clinic:</b>
<b>Patients and Clinicians should be aware of the following upon referral to the EWPCN LLAC:</b> <ul style="list-style-type: none"> <li>Wounds with significant tissue involvement or loss (exposed bone or tendon) are not within scope of this clinic.</li> <li>The Patient may need to walk 60 meters with assistive devices.</li> <li>Patient must be able to transfer independently and lie flat for 45min.</li> <li>The patient must be aware multiple appointments to EWPCN LLAC may be necessary &amp; home visits are not provided Patients that already have a specialized clinician (NSWOC, Wound specialist, Lymphedema therapist) already involved in lower leg or wound management (for example homecare) will be redirected back to their active team.</li> <li>By referring to the EWPCN LLAC you are consenting to have a wound swab collected on your behalf if clinically appropriate.</li> </ul>	
<b>Reason for Referral</b>	
<input type="checkbox"/> Vascular/ABI Assessment <input type="checkbox"/> Pressure Area/Redness <input type="checkbox"/> Lower Leg Edema <input type="checkbox"/> Wound  <input type="checkbox"/> AADL Renewal (compression or footwear)	
<b>Relevant Medical History</b>	
<ul style="list-style-type: none"> <li>Medication list attached? Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Does the client see a specialist? Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>If yes, specialist name and specialty:</li> <li>Completed or pending related referrals or diagnostic imaging? Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>If yes, where:</li> <li>Has the patient experienced compression therapy in the past/worn compression? Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>If yes, current compression level:</li> <li>Any care in place for active wounds or edema treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>	
<b>Additional Information/Treatment History:</b> (i.e. Sees a podiatrist, previously seen at a wound clinic, antibiotics prescribed for current condition, etc.)	

**Booking line 780-443-7477 | Fax completed form to 780-481-9149**