HPE Lower Limb Preservation Project - Vascular Referral (KHSC & PRHC)

Patient Information:

Surname: | Mobile #:
First: | Home #:
DOB: | Business #:
Gender: ○ M ○ F ○ Other: | Email:
HN: | Referring Provider: | Billing #:
Address: | Phone: | Fax:

Additional Patient Information:

**** Indicates a required field***

Patient's preferred name:

Patient's preferred language: ○ English ○ French ○ Other:

Please indicate if an interpreter is required

Best method of contact: ○ Mobile # ○ Home # ○ Buisness # ○ Email

Preferred Pronouns: ○ He/Him/His ○ She/Her/Hers ○ They/Them ○ Other:

Mobility: ○ Ambulatory ○ Wheelchair ○ Mechanical Lift

Where appropriate, please provide:

Alternate contact person: *Name* | *Phone* | *Relationship*

Referring Provider is not PCP: *Primary Care Provider's Name* | *Phone*

Special considerations:

i.e. 3rd party insurance, accesibility barriers, tips for care delivery

Preferred Location:

○ Kingston ○ Peterborough

Reason for Referral*

Urgency: ○ **Urgent** ○ Semi-Urgent ○ Next Available

If URGENT, provide details:

*Select all that apply:

- ☐ Leg/ foot pain at rest/ night
- ☐ Intermittent claudication
- ☐ Critical limb threat ischemia (CLTI)
  - ○ Non-healing ulcer *(Please specify)*
  - ○ Osteomyelitis
    - ☐ Failing on antibiotic treatment
  - ○ Deep tissue infection
  - ○ Gangrene/Ischemic Ulcer

If CLTI please call vascular on call:

-PTBO pager 705-304-2244 or 705-743-2121 x0 ask for vascular on call
-KGH call 613-548-3232 and ask for vascular on call

- ☐ Other:

Diagnosis

Medical History (select all that apply):

- ☐ Smoking ○ Current ○ Past
- ☐ Diabetes ○ Type 1 ○ Type 2 ○ Prediabetes
- ☐ CKD ○ Dialysis ○ EGFR < 30 ○ EGFR 30-50 ○ >50
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Heart Disease *(Please specify)*
- ☐ Stroke *(Please specify)*
- ☐ DVT
- ☐ PVD
- ☐ CAD
- ☐ Obesity
- ☐ History of previous lower extremity ulcer (healed) *(Please specify)*
- ☐ Previous intervention *(amputation, bypass, IVR angioplasty, stent or debridement)*

(Please specify)

Physical Exam/Additional Information

Signs of Infection

- ☐ Foul odour — Details:
- ☐ Erthyema periwound — Details:
- ☐ Copious exudate — Details:
- ☐ Probe to bone increased or uncontrolled pain — Details:
- ☐ Systemic signs of infection — Details:

Wound description

Location(s) (select all that apply) ○ Toe ○ Foot ○ Leg

Details:

Palpable pedal pulses ○ No ○ Yes

Results:

Buerger's Test completed ○ No ○ Yes

Results:

Antibotics ○ No ○ Yes

Include Med, Start Date/End Date & Route:

Foot deformities ○ No ○ Yes

Details:

Cumulative Patient Profile

☐ Attached CPP (Problem List, Past Medical History, Current Meds, Family History, Allergies)

Supporting Documentation

Please indicate all investigations completed and attach, if available:

ABPI: ○ Completed ○ None

Details:

Arterial Dopplers: ○ Completed ○ Pending ○ None

Details:

CT/CTA Scan: ○ Completed ○ Pending ○ None

Details:

Blood Work

Please attach if available: CBC, electrolytes, Creatinine, INR/PTT, Glucose/HbA1c

Please fax this form to the preferred location:
Peterborough - 705-743-9912
Kingston - 613-548-6153