Client Name:
PHIN:
Date of Birth
Address:
Postal Code:
Phone(daytime):

Wound Consult

1. **Past Medical /Surgery History**

2. **Current Medications: (Include MAR)**

3. **Allergies:**

4. **Location of Wound :**

5. **History of Wound:**

6. **Wound Etiology:**

☐ Trauma	☐ Neuropathic	☐ Diabetic	☐ Other (e.g rheumatoid
☐ Surgical	☐ Burn	☐ Malignancy	☐ Pressure - Stage # ___
☐ Vascular	☐ Venous	☐ Arterial	☐ Mixed

7. **Current Treatment:** Attached Wound Assessment Treatment Flowsheet if available

8. **Contributory History/Factor Influencing Healing**

☐ Diabetes	☐ Age	☐ Chemotherapy/Radiation
☐ O_2 Impairment	☐ Immunosuppressed	☐ Pressure, Friction , Sheer
☐ Edema	☐ Nutritional Compromise	☐ Moisture/Incontinence
☐ PVD	☐ Medications	☐ Immobility/Poor Mobility
☐ Smoking	☐ Infection	☐ Sensory Compromise

☐ Other (autoimmune, connective tissue disorder, etc.)

Client Name:
PHIN:
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Postal Code:
Phone(daytime):

Wound Consult

9. **Psychosocial Issues:** ☐ Not Applicable
   - ☐ Lives alone, no apparent support system, transport issues
   - ☐ Financial issues, purchase of supplies potential problem
   - ☐ Mental, physical, or emotional impairment preventing client or caregiver from participating in care
   - ☐ **Other Issues:**

10. **Client Goal Regarding Wound Healing:**

11. **Expected Outcome:**
    ☐ Healing ☐ Non- Healing ☐ Non-Healable

12. **Interdisciplinary Involvement:**

☐ Nutrition	☐ Surgeon or Specialist	☐ Foot and Leg Ulcer Clinic
☐ Occupational Therapist	☐ GP	☐ ET Nurse
☐ Physiotherapist	☐ Social Worker	☐ Resource Nurse
☐ Other		

13. **Braden Score:** (include most recent completed form)

14. **Intervention Checklist :**(include most recent completed form)

15. **History of Current Wound Treatments:**
    (include date, products used, wound response and any other pertinent information)

Signature: _____ **Date:** _____

Faxed To:	☐ Portage	(204)- 239-1278	**Date:**	
	☐ Steinbach	(204)- 326-2506	**Date:**	
	☐ Niverville	(844)-754-2445	**Date:**	