Integrated Specialist Healthcare
Education & Research Foundation

HealthOne SUTHERLAND

Wound Clinic Referral Form

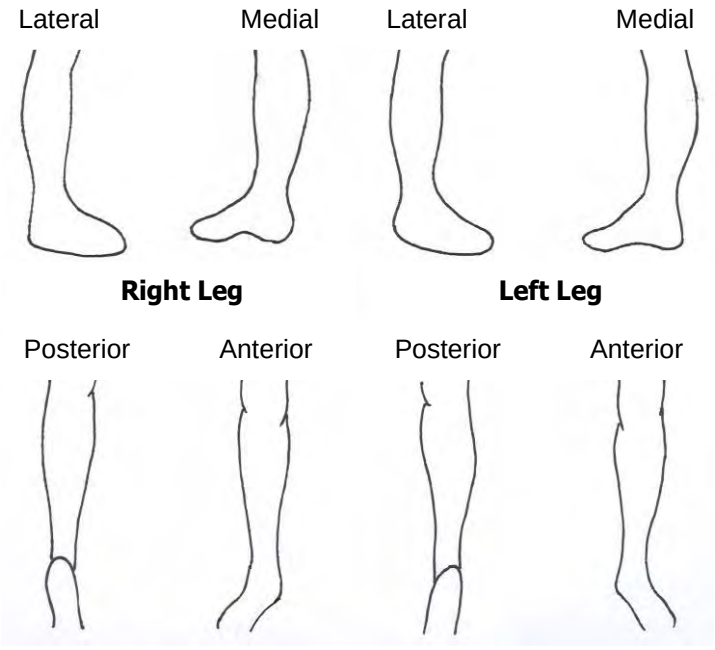
Patient Details	GP / Specialist Referrer Details
Name:	Name: .....
DOB:	Provider Number: .....
Address:...	Practice: .....
.....	Phone: .....
.....	Fax: .....
Phone:	Email: .....
Email:	Preferred method of contact: Fax □ Email □

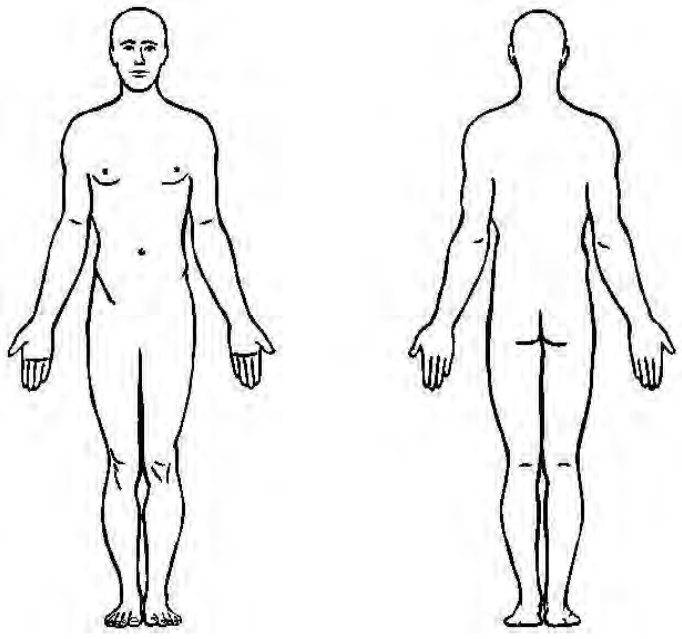
Do you have any of the following:

□ Diabetes | □ Arterial disease | □ Venous disease | □ Previous leg ulcers

If yes for previous ulcers what type and how long ago:

Please mark location of all current wound/s





Details of current wound/s needing review (e.g. duration, cause and who else has reviewed the wound):

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Please email this form back to Seslhd-tshiwcc@health.nsw.gov.au or Fax 9540 8164