



Patient ID

**Diabetic Foot Ulcer
 Rapid Access Referral Form**

FAX: (416) 864-5107

Referrer Information

Referrer Name:	
Practice/Clinic Name:	
Contact Phone Number:	
Fax Number:	
Date of Referral:	

Patient Details

Full Name:			
Date of Birth:			
OHIP Number (mandatory):			
Address:			
Phone Number:			
Email Address:			
Interpreter Required?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what language?:	
HbA1C (if available):			

Clinical Presentation

Ulcer Location (e.g., left plantar forefoot):			
Ulcer duration (days/weeks) if known:			
Signs of infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Signs of ischemia? (e.g. cold, pale, pulseless)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Exposed bone or suspected osteomyelitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Offloading in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		
Current or recent antibiotics use?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	If yes, details:	
Previous amputations? If known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	If yes, specify:	

Referrer Request for Consultation

- Telephone consult (please provide telephone number: _____)
- Virtual consult (e.g. Microsoft Teams - please provide email address: _____)

Choose time for Consultation

- Monday 11am 12pm 1pm
- Thursday 11am 12pm 1pm

Reason for Referral check (√) all that apply

- Diagnostic Tests (e.g. imaging, microbiology, vascular tests)
- Offloading/Casting
- Specialist Referral (e.g. surgical/medical)
- Wound Care
- Other: _____

Data Collection

If the Rapid Access Diabetic Foot Ulcer Clinic did not exist, how would you have handled your patient's foot issue?
– check (√) one

- Send the patient to the Emergency Department
- Send the patient to their family physician/NP/primary care
- Send to another specialist
- No action
- Other - please specify: _____

This referral does NOT replace the need for your patient to seek emergency care should there be an urgent medical issue.

By submitting this referral, the referrer confirms that the patient has been informed of and has consented to this referral and the sharing of relevant personal health information for the purposes of consultation and care.