COMPASS COMMUNITY HEALTH

Diabetes Foot Health Program

REFERRAL FORM

For your convenience, referrals can also be made via OCEANS

Please note: Admission to service is not guaranteed

CLIENT INFORMATION:

Name: _____

Date of Birth: _____ OHIP# _____Version: _____Exp: _____

Address: _____ City:_____ Postal Code: _____

Phone Number: (Home) _____ (Work): _____

☐ *Patient gives verbal consent to leave message on answering machine or with family member.*

Referring Physician: _____ Date: _____

Referring Source: ☐ **D.E.C** ☐ **FHT** ☐ **CHC** ☐ **Community Physician** ☐ **Hospital** **Other** _____

Patients will be triaged based on risk factors, level of need, self-care capacity and resources

All patients and caregivers are encouraged to attend the free Diabetes Foot Health Education classes in order to learn Safe Self Assessment and Self Care Practices

Please check eligibility criteria below:

☐ Diagnosis of : **Type 1 Diabetes** ☐ **Type 2 Diabetes** ☐ **A1C** _____

☐ Patient has financial or cultural barriers to obtain foot care services. Client **does not** have foot care coverage from private insurer.

☐ Patient **does not** have an existing foot ulcer, which is infected and or deeper that 5mm.

☐ Patient has an urgent issue needing immediate attention & can travel to any of our satellite clinics if need be.

☐ Patient is at **high to moderate** risk of foot complications because of their Diabetes (please complete checklist below):

If the client requires an urgent appointment, please specify in comments below. Those clients with infected wounds deeper than 5mm, active Charcot or critical ischemia **must be** medically stabilized prior to referral to the Diabetes Foot Health Program. Unfortunately, we are unable to perform advanced wound care or limb salvage.

One or more of the following conditions **MUST** be checked off for clients to receive foot care services by the Diabetes Foot Health Program:

☐	Diabetic Neuropathy (≥2 areas where sensation absent using 5.07mmHg monofilament)	
☐	Peripheral Artery Disease	
☐	eGFR ≤ 30 mL/min/1.73m^2	
☐	Previous foot ulceration	Date healed:_____
☐	Previous lower limb amputation	Date of procedure: _____
☐	Stable Charcot Foot	

Clients **not** meeting the above criteria will be offered a yearly comprehensive risk assessment and self-care information/classes.

Presently, we are unable to provide ongoing low risk foot care.

OTHER RELATED FACTORS (not considered eligibility criteria):

☐	Physical disability	☐	Callus/Corns
☐	Thickened Nails	☐	History of Ingrown Toenails
☐	Blindness	☐	Foot Deformity

Comments:

_____

_____

Please FAX referrals to the Diabetes Foot Health Program **905 667-8859**

Our referral for is also available on OCEANS.

PHYSICIANS: ***If you would like a report from the Foot Care provider please check here*** ☐

Fax number for report copy to be sent: _____