



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 than 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 you have completed an INLOW's diabetes foot screen please indicate the score below:

INLOW's Category	<input type="checkbox"/> Category 0 (Low) <input type="checkbox"/> Category 1 (Medium) <input type="checkbox"/> Category 2 (High) <input type="checkbox"/> Category 3 (Very High)	If the client requires an <u>urgent</u> 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.
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OTHER RISK FACTORS:

<input type="checkbox"/> Physical disability	<input type="checkbox"/> Retinopathy
<input type="checkbox"/> Diabetic Neuropathy	<input type="checkbox"/> Nephropathy
<input type="checkbox"/> Peripheral Artery Disease	<input type="checkbox"/> Previous foot ulceration
<input type="checkbox"/> Foot deformities	<input type="checkbox"/> Previous lower limb amputation

Comments:

Please FAX referrals to Compass Diabetes Foot Health Program

905 667-8859

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

Fax number for report copy to be sent : _____