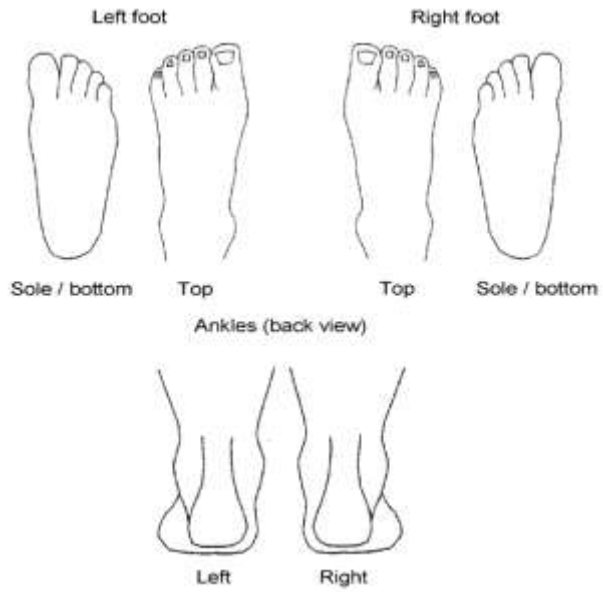
Diabetic Foot Ulcer Referral Form
Grey Bruce Health Services
FAX: 519-371-7695 PHONE: 519-371-2121 ext 2876

Patient Details

Name:	
Address:	GP/NP:
	Billing Number:
DOB:	Fax #:
Contact Number:	E-mail:



Please mark wound location.
Wound Details (e.g. previous treatment, dressings)

Duration of Ulcer:	Hgb A1c: Date completed:

Depth of Ulcer: ☐ Superficial ☐ Partial Thickness ☐ Full Thickness ☐ Bone Involvement

Is the ulcer clinically infected? ☐ Yes ☐ No

Diabetic Foot Ulcer Risk Stratification & Referral Algorithm Score:

☐ 0 ☐ 1 ☐ 2a ☐ 2b ☐ 3a ☐ 3b

Has offloading been provided? ☐ Yes ☐ No

If yes, please indicate type: ☐ Total Contact Casting ☐ Removable Cast Walker ☐ Custom Orthotics

***Please attach Cumulative Patient Profile (CPP) and send with referral

Signature: _____ Date: _____