Ontario
Health atHome

Medical Update Request Form - Wound

Physician / Health Care Provider: ____________________

OHaH Caseload: ____________________ Frequency of Visits: ____________________

Fax completed form to: ____________________ ____________________
Agency Fax Number

Patient Name: ____________________ DOB (dd/mm/yy): ____________ BRN: ____________

Diagnosis: ____________________ Allergies: ____________________

Present Status (Completed by Nursing Service Provider):

Wound: ☐ New ☐ Healing ☐ Non-Healing ☐ Maintenance **Odour:** ☐ Present ☐ Absent

Infection: ☐ Suspected ☐ Present **Osteomylitis:** ☐ Present ☐ Absent

Infection Management: ☐ Parenteral ☐ Oral Antibiotics ☐ Antimicrobial Dressing

No. of Dressing Changes/Wk: ________ **Size:** ________ LxWxD (cm) **Pain (0-10):** ________

Location: ____________________ **ABPI:** Right: ______ Left: ______ **Date (dd/mm/yy):** ________

Exudate: ☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large **Type:** ____________

Wound Bed: ☐ Granulation ☐ Slough ☐ Eschar ☐ Other: ____________________

Peri Wound Skin: ☐ Macerated ☐ Erythema ☐ Callous ☐ Dry and Intact ☐ Indurated ☐ Denuded ☐ Other: ____________________

Services Involved: ☐ ET (Name of ET): ____________ ☐ Chiropodist ☐ Dietician ☐ Social Work ☐ Physiotherapy ☐ Occupational Therapy ☐ Other: ____________

Other Information: ____________________

Current Treatment Concerns / Requests:

Request: ☐ Compression: ____________ ☐ Offloading Device ☐ Antibiotics ☐ Vascular Studies ☐ Blood Work ☐ ABPI Results ☐ Bone Scan/WBC ☐ Other: ____________

____________________ Signature ____________________ Print Name / Designation / Title

____________________ Agency / Extension ____________________ Date (dd/mm/yy)

Physician / Health Care Provider's Response / Orders: Specify wound etiology: ____________

☐ Best practice/evidenced based practice (Wound care outside of evidenced based practice may not be eligible for Ontario Health atHome services. Treatment will be taught and service reduced when appropriate).

____________________ Signature ____________________ Print Name / Designation / Title

____________ CPSO / CNO Reg. Number ____________ OHIP Billing Code [1] ____________ Date (dd/mm/yy)

Service Provider Use Only:

☐ Reviewed by Service Provider Initial: ________ Date (dd/mm/yy): ____________

1 Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.

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