Ontario Health atHome

Wound Consult Request – Virtual

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-800-811-5146 Fax: 519-472-4045

Patient Information

Surname		First Name
Home Address		
City		Postal Code
Health Card Number (HCN)	Version Code	Date of Birth (YYYY-Month-DD)
Gender Identity ☐ Male ☐ Female ☐ Undifferentiated ☐ Unknown		Pronouns ☐ He/Him ☐ She/Her ☐ They/Them

Virtual consultation is available for all wound types and patients, in any care setting that meets the eligibility criteria. At times, further investigations may be requested by the South West Regional Wound Care Program (SWRWCP) to support appropriate treatment recommendations.

Regardless of eligibility, if the SWRWCP determines that the complexity of the wound or the patient condition requires an in-person assessment, virtual consultation will end and the referral source will be notified of alternate options for an in-person wound assessment.

Form Instructions

Please fax the completed form to the South West Regional Wound Care Program toll-free at 1-833-243-8532 or by direct line at 519-637-4864.

Required Service – Select Only ONE (1)

Service	Eligibility Criteria
☐ NSWOC/WCS/ET	• A Nurse Specialized in Wound, Ostomy and Continence (NSWOC) or a Wound Care Specialist (WCS) or an Enterostomal Therapy Nurse (ET) is not accessible. • Has a nurse, community paramedic, or competent informal caregiver available and willing to attend virtual assessment and implement wound care recommendations. • Has access to technology to allow for wound visualization, i.e. smart phone, computer, tablet. • Patient does not demonstrate untreated signs of spreading systemic infection. i.e. a fever of 38°C or higher, or chills; increased drainage or pus; increased redness to the skin around the wound; skin around the wound becomes warm or hot to the touch; increased swelling; worsening pain in or around the wound; a new or worsening odour.
☐ Nurse Practitioner – Wound Care	• Patients with complex wounds requiring medical oversight and/or prescriber authorization related to the wound. • Patients with wounds that are not healing despite best practices, requiring further medical evaluation or investigation to support wound healing. • Patients with recurrent wound-related infections or emergency department visits. • Patients with wound recurrence within 6 months of wound closure. • Primary Care Provider requests for NP Wound Care specialized knowledge/ support.

Surname	First Name	Health Card Number

Reason for Consultation

Please provide a brief description of the history of the presenting concern and/or reason for consult request.

Wound Information

☐ Arterial Ulcer ☐ Diabetic Foot Ulcer ☐ Pressure Injury ☐ Skin Tear ☐ Surgical
☐ Venous Leg Ulcer ☐ Unknown ☐ Other _____

Wound(s) Location	Wound Measurements (L x W x D)

Consent Disclaimer

The patient, or substitute decision maker, has provided verbal or written consent for this referral.

☐ Yes ☐ No

Referrer Details

Referrer Name	Role/Title
Phone Number	Fax Number
Email Address	
Address	
City	Postal Code

Referrer Signature

Date Signed (YYYY-Month-DD)

A follow-up assessment, as deemed appropriate by the SWRWCP, will be completed within 2-4 weeks of initial consultation. If wound condition deteriorates prior to the arranged follow-up, please contact the SWRWCP by emailing SWRWCP@hccontario.ca to arrange a timely follow-up.