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| **A: Referral Will not be processed if this section not completed** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Date** | | | | | | | | |  | | | | | | | | | | | | | | | | **Health Service** | | | | | | | | | |  | | | | | | | | | | | |
| **Referring Nurse** | | | | | | | | |  | | | | | | | | | | | | | | | | **Designation** | | | | | | | | | |  | | | | | | | | | | | |
| **GP Name** | | | | | | | | |  | | | | | | | | | | | | | | | | **GP Contact No.** | | | | | | | | | |  | | | | | | | | | | | |
| **B: Reason for Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **🞏** | | Wound is Deteriorating/Not Improving | | | | | | | | | | | | | | | | | **🞏** | | | | | Symptom Management | | | | | | | | | | | | | | | | | | | | | | |
| **List Types of Symptoms** | | | | | **🞏** | | Pain | | | | | | **🞏** | Itching | | | | | **🞏** | | | | | Odour | | | | | | | | | | **🞏** | | Fatigue | | | | | | | | **🞏** | | Insomnia |
| **🞏** | | Incontinence | | | | | | | | | | | | **🞏** | | | | | Other, Specify | | | | | | | |  | | | | | | | | | | | | | | |
| **C: Location of Each Wound** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Wound 1** | | | | |  | | | | | | | | | | | | | | | | | | **Wound 2** | | | | | | | |  | | | | | | | | | | | | | | | |
| **Wound 3** | | | | |  | | | | | | | | | | | | | | | | | | **Wound 4** | | | | | | | |  | | | | | | | | | | | | | | | |
| **D: Insert wound number/s as indicated above, against each wound AETIOLOGY / TYPE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Skin Injury** | | | | **Pressure Injury** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stage 1 | | | | | |  | | | | | Stage 2 | | |  | | | | | | | | | Stage 3 | | | | | |  | | | | | | Stage 4 | | | | | |  | |
| Unstageable | | | | | |  | | | | | | | | | | | | | | | | | Suspected Deep Tissue | | | | | | | | | | | |  | | | | | | | |
| **Skin Tear** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type 1 | | | |  | | | | | | | | | | Type 2 | | |  | | | | | | | | | | | | | | | | | Type 3 | | | |  | | | | |
| **Dermatitis and Skin loss with moisture – associated damage** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **🞏** | | Incontinence (IAD) | | | | | | | | | **🞏** | Intertriginous | | | | | | | | | | | | **🞏** | | Periwound | | | | | | | | | | | **🞏** | | | Peristomal | | |
| **Other** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **🞏** | | Mucosal Pressure Injury | | | | | | | | | **🞏** | Medical – Adhesive related Skin Injury (MARSI) | | | | | | | | | | | | | | | | | | | | | | **🞏** | Radiation Dermatitis with Skin Loss | | | | | | | |
| **Typical Aetiology** | | | | Venous | | | | | |  | | | | | | | Arterial/ Ischaemic | | |  | | | | | | | | | | | | | | | | | Neuropathic | | | | | |  | | | |
| Neuro- Ischaemic | | | | | |  | | | | | | | Lymphatic | | |  | | | | | | | | | | | | | | | | | Mixed Disease | | | | | |  | | | |
| Abscess | | | | | |  | | | | | | | Fistula | | |  | | | | | | | | | | | | | | | | | Pilonidal sinus | | | | | |  | | | |
| Drain Tube | | | | | |  | | | | | | | Malignant | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Acute** | | | | **🞏** | | Surgical | | | | | | | | | **🞏** | Burn 🞏 Trauma other than Skin Injury: Specify. | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | |
| **Atypical Aetiology** | | | | Diagnosis | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | **🞏** | Diagnosis Unknown | | | | | | | |
| **E: Chronic Oedema Screen (in any area or limb that has a wound. Specific location not required)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **🞏** | Present for >3 months | | | | | | | | | | **🞏** | Soft-pitting (up to 60 seconds pressure) | | | | | | | | | | **🞏** | | | | Hard non-pitting | | | | | | | | | | | | | | **🞏** | | Positive Stemmers sign | | | | |
| **F: Attached History Referral will not be processed if 1) & 2) and 3) not provided** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **🞏** | **1** | | **Medical History** (GP Medical Summary & ACAS Comprehensive Assessment or NDIS Support plan) | | | | | | | | | | | | | | | | | | | **🞏** | | | | **2** | | | **Medications** (Current) | | | | | | | | | | | | | | | | | |
| **🞏** | **3** | | **Investigations** (All relevant reports/results e.g. Vascular, Radiology, Pathology / Biopsy) | | | | | | | | | | | | | | | | | | | **🞏** | | | | **4** | | | **Allergies/Sensitivities (Inc. Tape)** if not included in Medical Summary | | | | | | | | | | | | | | | | | |
| **G: Email form (page one ONLY if handwritten) and photos\*, in separate emails to:** [**monika.samolyk@gatewayhealth.org.au**](mailto:monika.samolyk@gatewayhealth.org.au) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*MAX of 3 CURRENT photos per wound including 1) Close-up of wound 2) Old dressing with exudate and 3) Wider area (Legs, abdomen etc). Referral will not be processed without photos however please DO NOT send excess photos.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |