island health

Long Term Care Services

Referral for Wound, Ostomy & Continence Consultation

(affix Resident label)

Owned and Operated sites - e-mail Referral to: LTCWOCconsult@VIHA.CA

Affiliated sites – *Fax Referral* to LTC Admin Office - Laurie Gnam: at 1-250-370-5676

Include the following documents with your consultation request as applicable:

- ☐ Braden Risk Assessment & Interventions Flowsheet
- ☐ MRSA or CPO positive
- ☐ Refer to EHR Record
- ☐ Photograph(s) (owned and operated sites only)
- ☐ Recent C & S Report
- ☐ Wound Assessment & Treatment Flow sheet (WATFS)
- ☐ Other Relevant Consultations/Reports

Date	Facility	Person completing form:	Contact #

(Resident name or affix label top of form) Room #	MRN#

Physician	GP Phone #	GP Fax #

Referral Urgency: ☐ 1-3 days ☐ 3-5 days ☐ stable 1-2 weeks

WOUND CONSULTATION:

Wound type (if Known)	✓	Plan of Care reviewed by	Date	Increase in	✓	For Lower leg wound	✓
Pressure Injury (1-4)__ ☐ Unstageable ☐ Medical Device ☐ Mucosal ☐ DTPI		(Circle) GP/NP Orthopedic/Vascular Plastics/Dermatologist Pharmacist/SW		New areas of breakdown		Vascular Assessment and Arterial/Brachial Index (ABI) completed Date:_____	
Moisture Associated Skin Damage (MASD)		Clinical lead/DOC		Wound pain		Pain on elevation or walking	
Venous		Resident & Family		Bleeding/redness		Edema/Lymphedema	
Arterial or Mixed		Dietitcian		size of wound		Pulses Palpable	
Diabetic		Physiotherapist		Necrotic tissue		Hair on Lower Legs?	
Skin Tear		Occupational Therapist		or change in drainage		Brown discoloration to gator area	
Malignant/Palliative		Physiatrist/Orthotist		Odor after cleansing		Dependant Rubor and/or blanching on elevation	
Inflammatory or unknown		Wound Clinic		Temperature		History of DVT	

Anatomical Location of Wound(s):

How long has wound been present?_____

Wound Measurements:(if owned and operated sites include recent photograph)

length _____ **width** _____ **depth** _____ **undermining** _____ **tunnelling** _____ **sinus** _____

Other Remarks: **MOST Intervention level** _____

(see page 2 for Ostomy & Continence Referral)

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OSTOMY CONSULTATION: (Please include contact information on Page 1)

Reason for Referral:

☐ **Colostomy** ☐**Ileostomy** ☐**Urostomy** ☐**Permanent** ☐**Temporary stoma**

Date of Surgery:_____

Peristomal skin condition:

☐Intact ☐Reddened ☐Wound ☐Hernia ☐Denuded ☐Rash

Description of Stoma: ☐Flush with Skin ☐ Retracted ☐ Protruding ☐ Prolapsed>2cm ☐Necrotic(black or sloughy)

Frequency/pattern:(if Urostomy –urine flow, frequency of UTI's) Description of stool- (use Continence Section below)

Other Remarks:

List Products used for stoma care:

Brand _____ ☐One Piece ☐Two Piece system ☐Ostomy Belt ☐Skin Prep ☐ Paste ☐mouldable strips ☐Stoma Powder

Size of flange _____ Pharmacy and phone number_____

CONTINENCE CONSULTATION (Please include contact information on Page 1)

☐Bowel Incontinence ☐Bladder Incontinence ☐ Frequent Catheter Bypassing

☐Frequent UTI's ☐Bladder Pain ☐Bowel & or Bladder Prolapse – stage if known _____

☐Incontinence Associated Skin Damage(IAD) ☐Pessary (Describe)

Description of stool: (use Bristol Stool Chart) Type _____

☐Easy to pass ☐ Straining to pass ☐ Painful to pass ☐Passing with blood ☐Sensation of didn't quite finish

IF CATHETER USE COMPLETE INFORMATION BELOW:

☐**Suprapubic Catheter** ☐**Indwelling Catheter** ☐ **In and out Catheter** ☐ **Nephrostomy Tube**

☐Urinary Retention/bladder outlet obstruction ☐client requiring prolonged immobilization

☐Improve comfort for end of life care ☐ Urologic surgery/ post-operative care

☐Assist in healing of open sacral/perineal wounds in incontinent client ☐ Other _____

Catheter insertion date: _____

Type/Brand _____ ☐Coude ☐Straight ☐Latex ☐Silicone Size _____

Balloon Size_____

Catheter Securement Device _____

Urinary Catheter Drainage bag(s) ☐ leg Bag ☐Night Bag

Date Catheter last changed: Frequency of changes:

Other Remarks: