Surname______________________ First Name_____________________
D.O.B.______/______/_______ NHI______________________
Address ____
Phone No___________________

Complex Wound Clinic: Middlemore Hospital

This referral cannot be actioned if there is insufficient supporting information.
Please fax completed referral to: 277-1600 int.3600 or email to woundcareservice@middlemore.co.nz.

Mobility status: Fully mobile / mobile with aide / chair or bed bound **Level of input required:** Email/phone discussion or outpatient appointment	**Relevant Medical History:** ____ ____ ____
GP Identification: ____	**Alert/risks:** – e.g. allergies, dressing reaction ____
Wound aetiology/causative factor, duration: ____ ____	**Is the wound covered under ACC:** Yes / No Date of injury: ……/……./…….. ACC No:___________
Please describe the reason for this referral/input required: ____ ____ ____	
Location of the wound in need of assessment: Front Back Right Left Left Right	**Description of the wound in need of assessment:** Size: Length: ____ cm Width: ____ cm Depth: ____ cm Wound bed appearance: Granulation: ____% Slough: ____% Necrotic: ____% Epithelial: ____% Facia: ____% Tendon: ____% Bone: ____% Other: ____% Exudate level: Dry/Moist/Wet/Saturated/Leaking Pain score 0-10: Rest: ____ Dressing Change: ____
Current and previous treatment plan: ____ ____ ____	**Investigation results: e.g. ABPI/TBPI, cultures** ____ ____ ____

Clinicians Name:	location:	Contact No:	Date:
________________________	___________________________	________________	……/……/…….
Email address: ____			