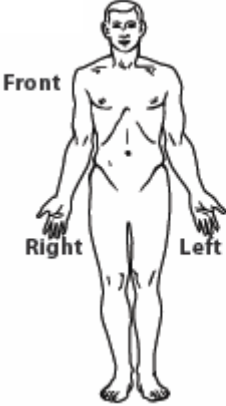
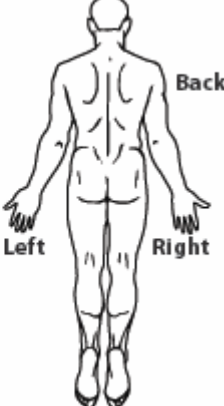


Surname _____	First Name _____
D.O.B. ____/____/____	NHI _____
Address _____	
Phone No _____	

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	Relevant Medical History: _____ _____ _____		
Level of input required: Email/phone discussion or outpatient appointment	Alert/risks: – e.g. allergies, dressing reaction _____ _____		
GP Identification: _____ _____	Is the wound covered under ACC: Yes / No Date of injury:/...../..... ACC No: _____		
Wound aetiology/causative factor, duration: _____ _____	Please describe the reason for this referral/input required: _____ _____ _____		
Location of the wound in need of assessment: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  </div> <div style="text-align: center;">  </div> </div>	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: _____			