



SWSLHD HIGH RISK FOOT SERVICE REFERRAL FORM

Bankstown HRFS accepts referral by Fax: 97228366 or Email: SWSLHD-Bankstown-HRFS@health.nsw.gov.au

Campbelltown HRFS accepts referrals by Fax 4634 4701 or Email: SWSLHD-MacarthurHighRiskFoot@health.nsw.gov.au

Liverpool HRFS accepts referrals by Fax: 8738 8297 or Email: SWSLHD-liverpoolhrfsreferral@health.nsw.gov.au

Patients living outside of the catchment area of SWSLHD are NOT eligible for referral

Dear _____ Date of referral: _____

Patient Information

Family name:	Given Names:
Sex:	Date of Birth
Address:	Aboriginal and Torres Strait Islander Status:
Contact number:	Alternative contact number:

Interpreter Required: Yes / No (Please Circle) Language:

Referral Details

Referral Reason: Please tick, needs meet at least of the following referral criteria:

- Foot wound
- Gangrene/ necrosis or critical limb ischaemia
- Suspected charcot arthropathy (oedema, erythema of foot and leg and possible change in foot structure that is not responding to antibiotics and DVT ruled out).
- Suspected or confirmed osteomyelitis or septic arthritis of the foot or localised foot infection

Please note if wounds are above the ankle, please refer to Community Nursing via Triple I-HUB

Wound History:

Wound Location (please tick)	Duration of wound (please tick)	Foot (please tick)
<input type="checkbox"/> Toes	<input type="checkbox"/> < 4 weeks	<input type="checkbox"/> Right foot
<input type="checkbox"/> Forefoot	<input type="checkbox"/> 4-12 weeks	<input type="checkbox"/> Left foot
<input type="checkbox"/> Midfoot	<input type="checkbox"/> > 12 weeks	
<input type="checkbox"/> Heel		

Wound Causation Details: _____

Previous treatment (please tick and enter details if required)

- Wound debridement
- Wound dressing. Details _____
- Antibiotics. Details _____
- Offloading. Details _____

Further comments/details

Please attach medical history and medications. Include all relevant pathology (HbA1c, eGFR and CRP), relevant investigations (x-rays, vascular studies, microbial results) and a clear wound photo.

Referring clinician

Referrers Name and Signature:	Phone:
Address/Practice Name:	Provider Number:
Email:	Fax: