AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Multi-Disciplinary Diabetic Foot Clinic Referral

MUST ATTACH PATIENT LABEL HERE

SURNAME: ____________________ NHI: ____________

FIRST NAMES: ____________________ DOB: ____________

Please ensure you attach the correct visit patient label

Referral Criteria: Diabetic patients with active foot ulceration/wounds and:

- Concerns regarding ischaemia (absent foot pulses) and/or
- Infection and/or
- Architectural/Charcot changes

Date:____________

Reason for referral:____

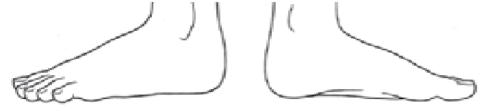
Wound Description and location:

____

____

____

Right Foot (mark location) **Left Foot (mark location)**



Pedal pulses palpable?

Right Post. Tibial: ☐ Yes ☐ No
Right Dorsalis Pedis: ☐ Yes ☐ No

Left Post. Tibial: ☐ Yes ☐ No
Left Dorsalis Pedis: ☐ Yes ☐ No

Current wound care/dressing plan:

____

____

Antibiotic therapy:

Is the patient on antibiotics? ____

Name, Dosage & Duration: ____

Relevant investigations & results (e.g. Blood tests, Imaging, swabs etc.)

____

____

Referrer's Details

Name:

Signature: Designation:

Contact details: Service:

*Please fax this form to **Department of Vascular Surgery, Auckland City Hospital** on 09 375 4357 (external referrals) or to extension 23908 (internal referrals)*

MULTI-DISCIPLINARY DIABETIC FOOT CLINIC REFERRAL

CR2250