ERIE ST. CLAIR COMMUNITY CARE ACCESS CENTRE
CENTRE D'ACCÈS AUX SOINS COMMUNAUTAIRES D'ÉRIÉ ST-CLAIR

Medical Update Request Form - Wound

Physician / Health Care Provider: ______________________

CCAC Caseload: ______________________ Frequency of Visits: ______________________

Fax completed form to: ______________________ ______________________
Agency / Fax Number

Patient Name: ______________ DOB (dd/mm/yy): ____________ BRN: ____________

Diagnosis: ______________________ Allergies: ______________________

Present Status (Completed by Nursing Service Provider):

Wound: ☐ New ☐ Healing ☐ Non-Healing ☐ Maintenance **Odour:** ☐ Present ☐ Absent

Infection: ☐ Suspected ☐ Present **Osteomylitis:** ☐ Present ☐ Absent

Infection Management: ☐ Parenteral ☐ Oral Antibiotics ☐ Antimicrobial Dressing

No. of Dressing Changes/Wk: ________ **Size:** ________ LxWxD (cm) **Pain (0-10):** ________

Location: ______________ **ABPI:** Right: ______ Left: ______ **Date (dd/mm/yy):** ________

Exudate: ☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large **Type:** ______________

Wound Bed: ☐ Granulation ☐ Slough ☐ Eschar ☐ Other: ______________

Peri Wound Skin: ☐ Macerated ☐ Erythema ☐ Callous ☐ Dry and Intact ☐ Indurated ☐ Denuded ☐ Other: ______________

Services Involved: ☐ ET (Name of ET): ____________ ☐ Chiropodist ☐ Dietician ☐ Social Work ☐ Physiotherapy ☐ Occupational Therapy ☐ Other: ______________

Other Information: ______________________

Current Treatment Concerns / Requests:

Request: ☐ Compression: ____________ ☐ Offloading Device ☐ Antibiotics ☐ Vascular Studies ☐ Blood Work ☐ ABPI Results ☐ Bone Scan/WBC ☐ Other: ______________

______________________ Signature

______________________ Print Name / Designation / Title

______________________ Agency / Extension

______________________ Date (dd/mm/yy)

Physician / Health Care Provider's Response / Orders: Specify wound etiology: ______________

☐ Best practice/evidenced based practice (Wound care outside of evidenced based practice may not be eligible for CCAC services. Treatment will be taught and service reduced when appropriate).

______________________ Signature

______________________ Print Name / Designation / Title

______________________ CPSO / CNO Reg. Number

______________________ OHIP Billing Code [1]

______________________ Date (dd/mm/yy)

Service Provider Use Only:

☐ Reviewed by Service Provider Initial: ________ Date (dd/mm/yy): ______________

1 Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.

PS 030a E JN15