Communication from Home Care Team to Referring Physician/RN(NP)
Saskatchewan Lower Extremity Wound Pathway

Attention: ______________________________

Fax #: ________________________________

Reason for communication:
☐ Information only
☐ Follow-up requested

Your patient was assessed by Home Care Team personnel on - date: ____________________

☐ ABPI Right: ______ Left: ______

 COMMENTS:

☐ TBPI Right: ______ Left: ______

☐ Wound Swab taken – date: ______________

TREATMENT INITIATED ACCORDING TO WOUND PROTOCOLS (NO FOLLOW UP REQUIRED)

Based on wound characteristics and discussion with the patient, treatment was initiated following the Saskatchewan LEWP best practice protocols. You will be notified of any subsequent changes in your patient’s condition or treatment.

The goal of treatment: ☐ Healable ☐ Non-Healable ☐ Maintenance

<table>
<thead>
<tr>
<th>PROTOCOL</th>
<th>Treatment initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ VENOUS STASIS ULCER</td>
<td>☐ Compression __________________________</td>
</tr>
<tr>
<td></td>
<td>☐ Wound dressing ________________________</td>
</tr>
<tr>
<td></td>
<td>☐ Other: _______________________________</td>
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<tr>
<td>☐ DIABETIC FOOT ULCER</td>
<td>☐ Compression __________________________</td>
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<tr>
<td></td>
<td>☐ Wound dressing ________________________</td>
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<tr>
<td></td>
<td>☐ Other: _______________________________</td>
</tr>
<tr>
<td>☐ ARTERIAL/ NON-HEALABLE WOUND</td>
<td>☐ Wound dressing ________________________</td>
</tr>
<tr>
<td></td>
<td>☐ Other: _______________________________</td>
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</tbody>
</table>

COMMENTS:

HOME CARE TEAM REQUESTING

Referral to specialist:
☐ Surgical consult: ____________________
☐ Foot deformities: ____________________
☐ Offloading Device: ____________________
☐ Other: ______________________________

Comments/ follow-up requested:

Clinician Name: __________________________ Date: __________________________

Phone Number: __________________________ Signature: _______________________