

Champlain Diabetes Chiropody Program

Referral Form

****Please note that all incomplete forms will be returned to the referring provider for more information and all client referrals will be triaged based on the information provided****

Referring Provider: _____ Phone Number: (____) _____

Fax Number (***required**): (____) _____ Request communication back? Yes No

Client Information:

Client Last Name: _____

Gender: M F

Client First Name: _____

DOB: (YYYY)/(MM)/(DD) ____/____/____

Client Phone: (____) _____

Alternate Phone: (____) _____

Language: English French Other: _____ **Client A1C:** _____

Client has: Type 1 Diabetes Type 2 Diabetes (Insulin, Oral and/or Diet) Pre Diabetes

Referral for: Assessment by Chiropodist /Group Health Education

- Loss of sensation at any one site
- Callus or corns present or abnormal foot shape (e.g. claw or hammer toes, bunion, obvious bony prominence, Charcot foot)
- Past history of Foot ulcer
- Absent pedal pulse and intermittent claudication
- Client requires education on proper diabetic foot care and has none of the conditions above

Urgent Appointment

Open wound/foot ulcer or Infected ingrown toenails

Details:

***** Please Note, our clinics do not provide routine nail care**

Preferred Location (Based on availability):

- Ottawa Beachburg Pembroke Renfrew Barry's Bay
- Lanark Kemptville Arnprior Carp Carleton Place
- Embrun Rockland Hawkesbury Cornwall Winchester

Please Fax *Completed* Referral to: **613-233-6713**



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