



Michener
CHIROPODY CLINIC
 Michener Chiropractic Clinic
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 T:416-596-3108 F:416-596-3183
 E: chiropodyclinic@michener.ca

Addressograph

Name: _____
 Male: Female:
 DOB: _____
 Address: _____
 Telephone: _____
 OHIP#: _____

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Contact Person: _____ Relationship: _____ Phone#: _____

Language of Correspondence: English Other _____

Reason for Referral: Routine wound care Offloading Total contact casting (TCC) Routine foot care
 Diabetes foot screen and education
Urgent **Non-Urgent** **SCOPE Physician** YES NO

Additional Information:

| Past History (Please check and circle) | Relevant Foot History | Additional Information for Wound/TCC Patients ONLY: |
|---|--|---|
| <input type="checkbox"/> Vascular Diseases Arterial Venous Lymphatic <input type="checkbox"/> Neurological Diseases CNS PNS Neuropathy <input type="checkbox"/> Metabolic/Endocrine Diseases <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Lower Limb Edema Venous CHF Renal Lymphatic Others: <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Balance Issues <input type="checkbox"/> Compromised Immune System <input type="checkbox"/> Current HBA1C _____ | <input type="checkbox"/> Foot Ulcerations (Active) <input type="checkbox"/> Foot Ulcerations (Past) <input type="checkbox"/> Lower Limb Amputations <input type="checkbox"/> Foot Deformities <input type="checkbox"/> Hx of Charcot Arthropathy <input type="checkbox"/> Severe Callus/Corns on the Feet | Has the patient had (ankle brachial pressure index) ABPIs/ (toe brachial index) TBIs and/or other Vascular diagnostics tests completed recently? Yes No <i>If possible, please include copies of results</i> Does the patient have an active infection requiring oral/IV antibiotics? Yes No Has the patient had a closed-toe, fibreglass Total Contact Cast before? Yes No Is the patient currently treated with a TCC? Yes No |

Referral Information:

Name of Referring Physician (Print): _____ Phone #/Pager: _____ CPSO #: _____

Signature of Referring Physician: _____ Date of Referral: _____ (DD/MM/YYYY)

Please Attach: List of Current Medications Relevant Imaging Results Relevant Lab Test Results