Form 02
Wound Assessment Referral
Send to: admin@acmns.au

Patient Details	
Full Name:	
Date of Birth:	
Facility Name:	
Room Number / Location:	
Medicare Number:	
Next of Kin (NOK) / Contact Person:	
GP Name and Contact:	

Referral Details	
Date of Referral:	
Referred By (Name & Title):	
Contact Number / Email:	
Reason for Referral:	
[ ] Initial wound assessment [ ] Wound deterioration [ ] Dressing recommendations [ ] Staff education/support [ ] Ongoing management	

Wound Details	
Location on Body:	
Type of Wound:	
[ ] Pressure injury [ ] Arterial ulcer [ ] Venous ulcer [ ] Diabetic foot ulcer [ ] Skin tear [ ] Surgical wound [ ] Other:	
Duration of Wound:	
Size (L x W x D):	
Wound Stage (if pressure injury):	
[ ] Stage 1 [ ] Stage 2 [ ] Stage 3 [ ] Stage 4 [ ] Unstageable [ ] SDTI	
Wound Bed Appearance:	
[ ] Slough [ ] Necrosis [ ] Granulation [ ] Epithelialising [ ] Mixed [ ] Other:	
Exudate Level:	
[ ] Nil [ ] Minimal [ ] Moderate [ ] Heavy [ ] Purulent	
Odour:	[ ] Yes [ ] No
Surrounding Skin:	
Pain Level (0-10):	
Current Wound Management	
Current Dressing in Use:	
Frequency of Dressing Change:	
Previous Treatments Attempted:	
Known Product Allergies:	
Current Wound Management	

Wound Product Recommendations	
Primary Dressing:	
Secondary Dressing:	
Additional Products:	
Recommended Dressing Frequency:	
Comments:	

Clinical Photo Consent
[ ] Consent obtained for wound photography [ ] Not obtained / declined

Recommendations / Wound Management Plan
(To be completed by ACMNS NP):

Communication & Follow-Up	
Review Date Recommended:	
Staff Notified:	[ ] Yes [ ] No - Name:
GP Notified:	[ ] Yes [ ] No - Name:
Family/NOK Informed:	[ ] Yes [ ] No Name of NOK:
Date/Time of Contact:	
Mode of Communication:	[ ] Phone [ ] In-person [ ] Email [ ] Other:
Summary of Discussion:	

OFFICE USE ONLY	
Education Provided to Staff:	[ ] Yes [ ] No
Resource Material Supplied:	[ ] Yes [ ] No
Clinician Details - ACMNS Wound 360 Solutions	
Name:	
Designation:	
Signature:	
Date of Visit:	