

Good Foot Forward

Provider Referral Form

Eligibility:

- 1. No access to foot care (i.e. no extended health benefits or ability to pay privately).**
- 2. Moderate Risk Criteria** with or without loss of protective sensation as per the assessment & triage tool.

Referral Date:

dd-mm-yyyy

Please fax completed form to: **705-797-2921**

Full Name:

Legal name if different:

Date of Birth: dd-mm-yyyy

Address:

Person's Phone Number:

Health Card Number:

VC:

Indigenous Self-Identification:

First Nation (Status) First Nation (non-Status) Métis Inuit Other: _____

Patient Information

Type 1 Diabetes Type 2 Diabetes No Diabetes

Peripheral Arterial Disease Yes No

Provider Information

Assessment and Triage Form Completed Yes No

Referring provider's name (diabetes educator, nurse, etc.):

Physician/Nurse Practitioner Name:

Physician/Nurse Practitioner Office Phone:

Physician/Nurse Practitioner Office Address: