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| **PODIATRY ASSESSMENT/****REFERRAL FORM** | newlogo-big |
| **For Administration Use only:****Emergency / Urgent / Routine: Clinic:****First Appointment** |
| **Please read this information before completing this form.****Podiatry treatments are given on the basis of medical risk, and foot health need, and may result in packages of care relating to the problem referred for, and may not always result in long-term treatments. If requesting a domiciliary visit you will need to confirm that the patient is incapable of travelling to attend a clinic appointment.****We do not provide a social nail cutting/skin care service.** |

**You must complete all sections in full so that we can identify your needs; if the form is incomplete it will be returned to you and may result in a delay.**

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| **Patient Information** |

Title: *Mr/Mrs/Ms/Miss or Other:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: *Male/Female:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile/Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Address/Stamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**N.B: For children under 16 years of age a person with parental responsibility must attend each appointment.**

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| **Reason for Podiatry Referral** |
| A weeping, discharging wound (are nursing team involved? YES / NO) |  | Foot infection requiring medication from the GP |  |
| In growing toe nail +/- Infection |  | Foot / lower limb pain for most or all of the day |  |
| Loss of sensation |  | Corns and / or significant callous |  |
| Thickened nails |  | Diabetic assessment – newly diagnosed / increased risk with podiatric need / high risk |  |
| Please provide a brief description of presenting foot complaint: |
| **Mobility Status** |
| **Patients who attend GP or Out Patient appointments are expected to attend Community clinic appointments. Should they choose not to travel they will not be offered an alternative.** |
| Able to attend clinic YES / NO | Able to walk unaided YES / NO |
| Walks with stick/frame YES / NO | Uses mobility scooter YES / NO |
| Uses wheelchair YES / NO | **Continued overleaf:** |

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| **Medical History** |
| Diabetes | YES / NO | Last HBA1c: |
| Last foot screen result | Low / Increased / High / Ulcerated |
| Neuropathy | YES / NO | Peripheral arterial disease | YES / NO |
| **Please tick all the boxes that apply:** |
| Immuno-suppression/deficiency |  | Neurological |  |
| Heart disease |  | Peripheral Vascular Disease |  |
| Stroke |  | End of Life Care |  |
| Kidney Disease – stage 4 & 5 (formally End Stage Renal Failure) |  | Chronic Severe Oedema including Lymph Oedema |  |
| Rheumatoid Arthritis (not osteoarthritis) |  | Connective Tissue Disorder e.g. Scleroderma, Hypermobility, SLE |  |
| Other Life Long Medical Conditions (Please specify) |
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| **Ethnic Origin: Please Tick The Category Below, Which Applies To You (Tick Only One Clear Box):** |
| British |  | White/Black Caribbean |  | Indian |  | Caribbean |  | Chinese |  |
| Irish |  | White/Black African |  | Pakistani |  | African |  | Any Other Ethnic Group |  |
| Any Other White Background |  | White/Asian |  | Bangladeshi |  | Any Other Black Background |  | Decline To State |  |
|  |  | Any Other Mixed Background |  | Any Other Asian Background |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Translator required YES / NOLanguage required: | Special appointment requests: |
| Have you attended the podiatry service in the past six months? YES / NO |
| Referrers Name |  | Referrers Designation |  |
| Signature |  | Date |  |
| **When you have completed all sections of this form please return it to:** |
| **Podiatry Service, Kingsgate House, Wellington Road North, Stockport SK4 1LW** |
| **Fax (Urgent refs from health professionals only)** | **0161 426 5463** |
| **Telephone** | **0161 426 5400/1** |