|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PODIATRY REFERRAL FORM** | | | | | | | | | | |
| **You must complete all sections on both sides in full so that we can identify your needs, if not the form will be returned to you. Please complete electronically where possible or use black ink.** | | | | | | | | | | |
| **We do not treat verrucae (warts), fungal nails, normal nails or provide surgical shoes.** | | | | | | | | | | |
| **On Receipt Of Your Application**  **After assessing details on your referral form you will either:**   1. **Be offered an appointment with follow up treatment for your foot problem.** 2. **Be offered an intensive course of treatment and discharged.** 3. **Be discharged with foot health advice if your foot health needs are below NHS eligibility levels.** | | | | | | | | | | |
| **Details of private, registered podiatrists can be obtained from The Health & Care Professionals Council (**[**www.hcpc-uk.co.uk**](http://www.hcpc-uk.co.uk) **or Royal College Of Podiatry (www.rcpod.org.uk/find-a-podiatrist).** | | | | | | | | | | |
| **Patient Information** | | | | | **GP Information** | | | | | |
| **NHS Number:** | | | | | **GP Name:** | | | | | |
| **Title:** *Mr/Mrs/Ms/Miss/Other:* | | | | | **Practice:** | | | | | |
| **First Name(s):** | | | | | **Address:** | | | | | |
| **Surname:** | | | | |
| **Gender:** | | | | |
| **Date of Birth:** | | | | |
| **Address:** | | | | | **Phone Number:** | | | | | |
| **Email Address:** | | | | | |
| **Postcode:** | | | | | **Referrer Information *please leave blank if self-referral*** | | | | | |
| **Primary Phone Number:** | | | | | **Name:** | | | | | |
| **Alternative Phone Number:** | | | | | **Job Title:** | | | | | |
| **Email Address:** | | | | | **Address:** | | | | | |
| **Next of Kin** | | | | |
| **Name:** | | | | |
| **Telephone Number:** | | | | | **Phone Number:** | | | | | |
| **Relationship:** | | | | | **Email Address:** | | | | | |
| **NB: For children under 16 years of age a parent/guardian must attend each appointment.** | | | | | | | | | | |
| **Ethnic Origin - *Please put an X in one box only, next to the category below which applies to you*** | | | | | | | | | | |
| **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** | |  | ***Continued Overleaf:*** | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Presenting Foot Complaint / Original Reason For Referral –**  ***Please give as much information as possible, including location of pain, pain levels and any known history of the problem. Where possible please attach photographs of the problem area.*** | | | | | | | | | | |
| ***This section is essential, if not completed the form will be returned to you*** | | | | | | | | | | |
| **Please put an X in YES or NO - *Please add more details in the right-hand side space*** | | | | | | | | | | |
| **Foot Ulcer or Foot Wound** | | | | | **YES** |  | **NO** |  | **Site & details**  **& details of previous foot ulcerations** |  |
| **Weeping / discharging wound?**  **Infection / gangrene?** | | | | | **YES** |  | **NO** |  | **Site & details:** |  |
| **Antibiotics for foot related problem?** | | | | | **YES** |  | **NO** |  | **Name of antibiotics:** |  |
| **Any red, hot &/or swollen joints or soft tissue areas?** | | | | | **YES** |  | **NO** |  | **Site & details:** |  |
| **MEDICAL HISTORY - *Please put an X in the following boxes that apply to you*** | | | | | | | | | | |
| **Diabetes?** | **Type1** |  | | **Type 2** | |  | **NO** |  | **Comments:**  **(including latest HbA1c)** |  |
| **Diabetic Foot Risk-Rating, if known:** | **Low** |  | | **Moderate** | |  | **High** |  | **Active** |  |
| **Please put an X in YES or NO - *Please add more details in the right-hand side space*** | | | | | | | | | | |
| **Rheumatoid Conditions?** | **YES** |  | **NO** | | |  | **Details** |  | | |
| **Circulatory Problems?**  ***Please state information regarding pedal pulses, Doppler readings or any previous vascular surgery*** | **YES** |  | **NO** | | |  | **Details** |  | | |
| **Dementia?** | **YES** |  | **NO** | | |  | **Details** |  | | |
| **Bedbound?** | **YES** |  | **NO** | | |  | **Details** |  | | |
| **Clinical Frailty Score?**  ***If known*** |  | | | | | | **Details** |  | | |
| **Any other illnesses or allergies?**  ***(Please give details or attach a medial summary)*** | | | | | |  | | | | |
| **Medications?**  ***(Please list any medicines you are currently taking***  ***-attach additional information where necessary)*** | | | | | |  | | | | |
| **Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | **Please return the form to: buc-tr.podiatry@nhs.net**  **Podiatry Office, Brookside Centre, Station Way East, Aylesbury, Bucks, HP20 2SR**  **Tel: 01296 831110 Revised October 2021** | | | | |