

For office use only



Date Referral Received

Chi :

NHS Highland Podiatry Service DOES NOT undertake nail care

Each patient will be assessed so an individually tailored management plan can be agreed.

Treatment may not be given during this initial assessment.

Please return completed electronic forms to:

nhsh.southandmidpodiatry@nhs.scot

(Please mark e-mail "new referral")

Incomplete forms will be returned which will delay any issuing of an appointment

First name:		DOB:	
Surname:		Title	
Address:		Home	
		Mobile	
Post Code		e-mail	
GP Practice			

Reason for referral. *Please describe as fully as possible the problem you have with your feet. This section is important in enabling us to assess the urgency of your referral.*

How do you think Podiatry can help?

How long have you had this problem?

Less than 2 wks 2-12 weeks 3-12 months Over 1 year

Is the problem area red?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the problem area swollen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the problem area bleeding / discharging / weeping?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you currently taking, (or have recently taken), antibiotics for this problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Have you had treatment for this problem before? Yes No

If Yes please state where and by whom.

Do you have Diabetes?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>If YES</i> please tick the box that represents your diabetes foot risk category at your last foot check up.			
Low Risk <input type="checkbox"/>		Moderate Risk <input type="checkbox"/>	High Risk <input type="checkbox"/>
Active Foot Disease <input type="checkbox"/>		Don't Know <input type="checkbox"/>	
I've never had my feet checked <input type="checkbox"/>			
Please list all other medical conditions			
If NONE please tick this box <input type="checkbox"/>			
Please list all current medications (<i>attach a prescription tear-off slip if possible</i>)			
If NONE please tick this box <input type="checkbox"/>			
Allergies?	Yes <input type="checkbox"/>	<i>specify</i>	No <input type="checkbox"/>

Is there any other information you wish to add?

Appointment Support:	If you require communication support please specify below
British Sign Language interpreter <input type="checkbox"/>	Language interpreter <input type="checkbox"/> (Language _____)
Do you have a physical disability?	Yes <input type="checkbox"/> <i>Specify</i> _____ No <input type="checkbox"/>

Emergency Contact			
Name		Tel. no.	
Print name:	Date:		
Relationship if completing on behalf of patient:			

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