


<i>For office use only</i>		 NHS Highland Location code
MPI	Chi	
Urgent / Routine / MSK		
Date referral received		

NHS Highland Podiatry Service DOES NOT carry out SIMPLE nail cutting

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 forms to:
 Highland Podiatry Centre, 24 Abban Street, Inverness, IV3 8HH (Tel. 01463 723250)

All sections must be completed in BLOCK CAPITALS

Personal Information			
Name:		M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth:
Address:		Telephone numbers	Home
			Mobile
			Work
Postcode:		e-mail	
GP Information			
GP Practice		Tel. no.	

Emergency Contact	
Name	Tel. no.

Appointment Support:	If you require communication support please specify below
British Sign Language interpreter <input type="checkbox"/>	Language interpreter <input type="checkbox"/> (language
Other <input type="checkbox"/> specify.....	None required <input type="checkbox"/>






Do you have a physical disability?	Yes <input type="checkbox"/> Specify	No <input type="checkbox"/>
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Reason for referral (you can select more than one option)	Side: Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/>
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Region:	Toes <input type="checkbox"/> Heel <input type="checkbox"/> Arch <input type="checkbox"/> Top of Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Back <input type="checkbox"/>
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Structure:	Nails <input type="checkbox"/> Skin <input type="checkbox"/> Muscle/Tendon <input type="checkbox"/> Joint <input type="checkbox"/> Other <input type="checkbox"/> (specify
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Is the problem causing pain?	Yes <input type="checkbox"/> (use X to indicate pain level on scale below)	No <input type="checkbox"/>
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No Pain	0 	1 	2	3	4	5 	6	7	8	9 	10 	Worst Pain Ever
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Reason for referral <i>(Please complete the relevant boxes below)</i>	Yes	No
Is the problem area red?		
Is the problem area swollen?		
Is the problem area bleeding / discharging / weeping?		
Are you currently taking, (or have recently taken), antibiotics for this problem?		

How long have you had this problem?

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

Have you had treatment for this problem before? Yes No

If Yes please state where and by whom.

Do you have Diabetes? Yes No

If YES please tick the box that represents your foot risk category at your last foot check up.

Low Risk Moderate Risk High Risk Active Foot Disease Don't Know

I've never had my feet checked

Please list all other medical conditions

If **NONE** please tick this box

Please list all CURRENT MEDICATIONS *(attach a prescription tear-off slip if possible)*

If **NONE** please tick this box

Allergies? Yes *specify* _____ No

Is there any other information you wish to add?

Is the problem preventing you from attending work / school?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you self employed or work for a small company (fewer than 250 people)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Print name:	Sign:
Date:	
Relationship if signing on behalf of patient:	

Please note incomplete forms will be returned which may result in a delay in issuing an appointment