Send COMPLETED form to:
Podiatry Department
Newholme Hospital, Bakewell. DE45 1AD
Or email to address below

NHS
Derbyshire Community Health Services
NHS Foundation Trust

REQUEST FOR COMMUNITY PODIATRY ASSESSMENT

The information given on this form will be entered onto a computer and under the terms of the DATA PROTECTION ACT 1998 will be treated in a secure and confidential manner.

Please complete in full, in BLACK ink, or it may need to be returned for further information. The referral will be triaged by a member of the podiatry team and you may not be offered an appointment if you are not eligible for NHS podiatry.

Return to: - Local Clinic or Email to DCHST.Therapydirect@nhs.net

ABOUT THE PATIENT

Title	First Name(s)	Known as (or preferred name if different)
Surname/Family Name	NHS Number	Date of Birth
Home Address Post Code		
Tel No (including code)	Mobile No.	

Consent for messages to be left on the home phone	YES / NO
Consent for messages to be left on the mobile phone	YES / NO
Consent to share your electronic records (to share your record here with your GP)	YES / NO
Consent to share your Summary Care Record (to see your medication list)	YES / NO
Is an interpreter required?	YES / NO

Is treatment being received for any of the following:	Diabetes	YES / NO
	Loss of sensation in feet	YES / NO
	Heart Disease	YES / NO
	Poor circulation	YES / NO
Please specify any other medical conditions that are currently being treated or have been treated in the past		
Please list all medication you are currently taking: (attach additional documents if required)		
Please state any allergies you have:		
Please give a description of the foot problem/reason for request. Include as much detail as you can. This will help us to offer a suitable appointment. For example: Foot pain, swelling, redness or discharge. How long have they had the problem? Do they have a fall or balance problem?		
Please give any other information you feel we should know or any help you need with the appointment.		

Referrer (print name): Date: