

Send COMPLETED form to: Podiatry Department

Newholme Hospital, Bakewell. DE45 1AD Or email to address below

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 (incl. 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 thatare 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_