

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**](mailto: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 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_