**Referral Form for Podiatry**

EPUT Podiatry Service needs to ensure it provides your patients with the right service at the right time. Please help us to do this by **completing all sections of this form** so that your patient’s treatment is not delayed.

**We do not cut non-pathological toenails, treat verrucae or issue shoes**

**INCOMPLETE FORMS AND THOSE NOT MEETING OUR ACCESS CRITERIA WILL BE RETURNED**

**NHS Podiatry is for patients at high risk and is only available to people with a medical condition that adversely affects their feet.  Eligibility is not related to age.  Patients with a podiatry problem and at least one of the following conditions are eligible for our service**:

* Foot problems relating to diabetes (moderate and high risk)
* Circulatory disorders
* Steroid/chemotherapy
* Warfarin therapy
* Neurological problems
* Rheumatoid arthritis
* Wounds, ulcers and any other acute condition such as inflamed/infected in-growing toenails.

Please return forms via email to; **epunft.southeastpodiatry@nhs.net**

Tel queries to: **01375 364465**

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| --- | --- |
| Date of Referral:  | NHS Number: |
|  |
| **Patient Details** |
| Forename:  | Surname:  |
| Address and Postcode:  |
| Date of Birth:  | Gender:  |
| Home Telephone No:  | Mobile Telephone No:  |
| Ethnicity: Main spoken language:  |
| Next of Kin telephone No: |
| Consent to SMS |

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| **Disabilities (please indicate relevance to this referral)** |
| [ ]  Learning disability | [ ]  Physical impairment | [ ]  Sensory impairment |
| [ ]  Mental Health condition | [ ]  Longstanding illness | [ ]  Other |
| Additional Information: |

|  |
| --- |
| **GP Details** |
| Registered GP:  | Telephone:  |
| GP Practice or F Code:  |  |
| Have they received NHS Podiatry previously?  | Yes [ ]  No | [ ]   |
| If yes, when: | and where |
| Why do you want to make an appointment for this patient? Please specify any symptoms etc. |
| How long has this problem been there?  |
| If your patient experiences any pain, how bad is it? |
| [ ]  None | [ ]  Low | [ ]  Medium | [ ]  High |
| **Is there any discharge from break in the skin?** | [ ]  Yes |  [ ]  No |

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| **Medical History** |
| [ ]  Allergies. | [ ]  End Stage Renal Failure | [ ]  Diabetes |
| [ ]  Rheumatoid Arthritis | [ ]  Significant Vascular Disease of the lower limb | [ ]  Heart/Stroke |
| [ ]  Anticoagulant Therapy | [ ]  Neurological Disorder | [ ]  Active Cancer |
| **\*\*\*Mandatory section for diabetic patients,****referral will not be processed without this information\*\*\*** |
| Diabetes | [ ]  Yes | [ ]  No |
| If yes, please complete the following: |
| How long have they been diagnosed with diabetes?  |
| Date of last diabetic annual foot check: |
| Palpable pulses:  | R/F | L/F | √ = Palpable pulses |
| Dorsalis pedis  |  |  | X= Absent pulses |
| Posterior Tibialis  |  |  | √= Normal sensation |
| Monofilament test:  |  |  | X= Impaired sensation |
| **HbA1c results:**  |  |
| 2. Neurological disorder | [ ]  Yes | [ ]  No |
| If yes, what type? (e.g. Parkinson’s, Multiple Sclerosis, Stroke) |
| 3. Vascular Disease  | [ ]  Yes | [ ]  No |
| If Yes, what type? |  |
| 4. Other - please specify anything not listed above(e.g. Cancer, learning difficulties, COPD) |  |
| Major Active Problems for medical history:  |
| Current Consultation  |
| Relevant Previous Medical History:  |
| Current Medication: |

**SEE AT CLINIC:**

HOUSE BOUND: YES / NO

DOES PATIENT NEED TRANSPORT? :YES / NO

**TO BE ELIGIBLE FOR A HOME VISIT PATIENT MUST MEET ONE OF THE FOLLOWING CRITERIA:**

• Bed or Chair bound 24/7

• Require hoisting in order to be moved to travel

• Deemed too clinically ill to be expected to travel

• Seeing District Nurse

|  |  |
| --- | --- |
| **Referrer Details** (complete if not patient’s GP) |  [ ]  Select if patient’s GP |
| Name:  | Job Role:  |
| Organisation\Service:  | Telephone:  |

*Information on this questionnaire is protected under the Data Protection Act 1984 and will only be used by Essex Partnership University NHS Foundation Trust*