**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**](mailto: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: | | |

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| **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

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| --- | --- |
| **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*