Podiatry Referral Form

Dear Patient

HELP US TO HELP YOU.
Please read the documents in the package the Doctor/Nurse has issued to you. If you would like an assessment with the NHS Chiropodist/Podiatrist please complete this form.
*** Please print clearly**

Title Mr/Mrs/Miss/Ms/Master/other. If other specify _____

Name _____ Date of Birth _____

If under 16 please provide name of parent/guardian _____

Address _____

_____ Postcode _____

Tel No Home _____ Work _____ Mobile _____

G.P. Name _____

Referred by Self/G.P./Health visitor/Practice nurse/District nurse/Other

If other please specify _____

Other Professionals involved in your care _____

Ethnic origin: (these categories are those used in the national census)

White:	British ☐	Irish ☐	other white background ☐				
Mixed:	white/black Caribbean ☐	white/black African ☐					
	white/asian ☐	other mixed background ☐					
Asian or Asian background ☐	Indian ☐	Pakistani ☐	Bangladeshi ☐				
	any other Asian background ☐						
Black or Black British:	Caribbean ☐	African ☐	other black background ☐				
Other ethnic group:	Chinese ☐	Other ☐					
Not stated ☐							

Medical History

Do you have the following condition? If so please tick box

Diabetes	☐	Stroke	☐	Rheumatoid Arthritis	☐
Varicose Veins	☐	Poor Circulation	☐	Mobility Problems	☐

Other _____

Medication/Tablets

Do you take any medication?	Yes / No
Are you taking any Steroids?	Yes / No
Are you taking any Anticoagulants?	Yes / No

Please list any Medications:

*** If you have a spare copy of your current repeat prescription, please include this**

Have you any Allergies Yes / No Describe _____

Why do you NEED Podiatry/Chiropody?

_____

_____

_____

_____

Are you receiving any treatment for this problem elsewhere? Yes / No

Have you been a patient in the NHS Chiropody/Podiatry Service before? Yes / No

Comments / Further Information

Is there any day/time you can not attend?

Please tick which clinic you wish to attend

Carlisle	☐	Brampton	☐	Longtown	☐	Alston	☐
Wigton	☐	Silloth	☐	Aspatria	☐	Penrith	☐
Keswick	☐	Appleby	☐	Shap	☐	Kirkby Stephen	☐

*This form must be completed in full. If you do not do this the form will be returned to you for completion. The aim of this form is to make the pathway to the Podiatry Service faster.

Patient's Signature: _____ Date: _____

Once completed return to:

Podiatry Department
Penrith Health Centre
Bridge Lane
Penrith
CA11 8HW

For Office Use Only

Date Received: _____

Assessment Date: _____

Cpas No: _____

Triage Date:

Priority: Urgent

Non Urgent

Hospital

Clinical Status:

R ☐

B ☐

P ☐

T ☐

RH ☐

D ☐

Podiatrist's Signature: _____

Print Name: _____

Patient Contact Details

Date: _____

_____

_____

_____

_____

_____

Outcome: Assessment / Discharge

Practitioner: _____ Signature: _____