

For office use only



Date Referral Received

Chi :

NHS Highland Podiatry Service DOES NOT undertake nail care

Each patient will be assessed so an individually tailored management plan can be agreed.

Treatment may not be given during this initial assessment.

Please return completed forms to:

Highland Podiatry Department, 24 Abban Street, Inverness IV3 8HH (Tel. 01463 723250)

Incomplete forms will be returned which will delay any issuing of an appointment

First name:		DOB:	
Surname:		Title	
Address:		Home	
		Mobile	
Post Code		e-mail	
GP Practice			

Reason for referral. *Please describe as fully as possible the problem you have with your feet. This section is important in enabling us to assess the urgency of your referral.*

How do you think Podiatry can help?

How long have you had this problem?

Less than 2 wks 2-12 weeks 3-12 months Over 1 year

Is the problem area red?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the problem area swollen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the problem area bleeding / discharging / weeping?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you currently taking, (or have recently taken), antibiotics for this problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Have you had treatment for this problem before? Yes No

If Yes please state where and by whom.

Is the problem causing pain? Yes <input type="checkbox"/> (use X to indicate pain level on scale below) No <input type="checkbox"/>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Ever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Do you have Diabetes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
------------------------------	------------------------------	-----------------------------

If YES please tick the box that represents your diabetes foot risk category at your last foot check up.

Low Risk Moderate Risk High Risk Active Foot Disease Don't Know

I've never had my feet checked

Please list all other medical conditions

If **NONE** please tick this box

Please list all current medications (attach a prescription tear-off slip if possible)

If **NONE** please tick this box

Allergies?

Yes specify

No

Appointment Support:

If you require communication support please specify below

British Sign Language interpreter Language interpreter (Language _____)

Do you have a physical disability?

Yes Specify

No

Emergency Contact

Name

Tel. no.

Print name:

Date:

Relationship if completing on behalf of patient:

Please note incomplete forms will be returned which will delay any issuing of an appointment