PODIATRY ASSESSMENT/ REFERRAL FORM

Buckinghamshire Healthcare NHS Trust

NHS

For Administration Use Only:

Podiatry Number: Emergency/Urgent/Routine:

Clinic: Type Of Clinic:

Duration: First Appointment:

You must complete all sections in full so that we can identify your needs, if not the form will be returned to you.

We do not treat verrucae (warts), fungal infections or normal nails

On Receipt Of Your Application:

After assessing details on your referral form you will either:

1. Be offered an appointment with follow up treatment for your foot problem.
2. Be offered an intensive course of treatment and discharged.
3. Be discharged with foot health advice because your foot health needs are below NHS eligibility levels.

Details of private, registered podiatrists can be obtained from The Health Professions Council (020 7582 0866 or www.hpc-uk.org), Yellow Pages or local telephone directories.

Patient Information:

Title: *Mr/Mrs/Ms/Miss or Other:* _____ NHS Number: _____

Surname: _____

First Name(s): _____

Date Of Birth: _____ Sex: *Male/Female:* _____

Address: _____

_____

_____ Postcode: _____

Home Phone: _____ Mobile/Work: _____

E-Mail Address: _____

Doctor's Name: _____ Practice Phone No: _____

Practice Address/Stamp: _____

_____

Next Of Kin:

Name: _____ Relationship: _____

Telephone No: _____

NB: For children under 16 years of age a parent/guardian must attend each appointment.

Ethnic Origin: Please Tick The Category Below, Which Applies To You (Tick Only One Clear Box):

British		White/Black Caribbean		Indian		Caribbean		Chinese	
Irish		White/Black African		Pakistani		African		Any Other Ethnic Group	
Any Other White Background		White/Asian		Bangladeshi		Any Other Black Background		Decline To State	
		Any Other Mixed Background		Any Other Asian Background					

Continued Overleaf:

Application Forms Must Be Completed On Both Sides

Foot (Or Foot Related Problem)

Please Describe Your Foot (Or Foot Related) Problem: _____

_____

_____

Please Tick If Your Foot Has:

A Weeping/Discharging Wound Yes ☐ No ☐ Details: _____

Inflamed Area (Red, Hot & Swollen) Yes ☐ No ☐ Details: _____

Orthopaedics (Insoles & Orthotics) – Not The Provision Of Surgical Shoes

Pain – Part Of The Day/All Day Yes ☐ No ☐ Details: _____

Pain With Activity Yes ☐ No ☐ Details: _____

Soft Tissue Injury Yes ☐ No ☐ Details: _____

Joint Swelling Yes ☐ No ☐ Details: _____

Medicines: Please Tick One Box On Each Line:

Antibiotics (For Foot Related Problems) Yes ☐ No ☐

Do you Carry Any Medical Alert Cards? Yes ☐ No ☐ Details: _____

Please List Any Medicines You Are Currently Taking: _____

_____

_____

Medical History:

Please Tick The Following Boxes As They Apply To You:

Circulatory Problems (Please Specify) Yes ☐ No ☐ Details: _____

Diabetes Yes ☐ No ☐ Details: _____

Rheumatoid Conditions Yes ☐ No ☐ Details: _____

Foot Ulcers – infections/gangrene wounds Yes ☐ No ☐ Details: _____

Spinal Unit Yes ☐ No ☐ Details: _____

Any Other Illness Please Give Details: _____

_____

Signature: _____ Date: _____

Print Name: _____

Designation Of Person Referring: _____

If the patient suffers from poor circulation of the lower limbs please state information regarding pedal pulses, Doppler readings and any previous vascular surgery (if any):

_____

_____

Application Received (Date Stamp):

Please Return To:

Podiatry Office
Brookside Centre
Station Way East
Aylesbury
Bucks HP20 2SR
Tel: 01296 566459
FAX: 01296 566454
podiatry@buckshealthcare.nhs.uk