

APPLICATION FOR PODIATRY ASSESSMENT

Please note –the Podiatry Service does NOT provide routine nail cutting unless you are classed as medically high risk e.g. High Risk Diabetic or severe circulation problems

| | | | | | | | | |
|---|--|---|------------|-----|-----------------------------------|-----|--|----|
| NHS NO | | TITLE (tick) | MR | MRS | MISS | | | |
| SURNAME | | FORENAME | | | | | | |
| Date of Birth | | FAMILY GP NAME & ADDRESS | | | | | | |
| FULL ADDRESS | | | | | | | | |
| POSTCODE | | NEXT OF KIN/ CARER CONTACT | Name: | | | | | |
| | | | Telephone: | | | | | |
| ☎ Preferred Telephone Number: | | Consent to leave answer phone messages & send text | | | | | | |
| | | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| Email Address: | | | | | | | | |
| | (by supplying your email; we will assume we have consent to contact you in this way) | | | | | | | |
| Need an Interpreter | | Please state language | | | | | | |
| REASON FOR REFERRAL / WHAT IS YOUR FOOT PROBLEM? | | | | | | | | |
| | | | | | | | | |
| ARE YOU DIABETIC? | Yes | | No | | DO YOU HAVE AN OPEN WOUND? | Yes | | No |
| REFERRED BY: | Patient | | Carer | | Health Care Professional | | | |
| Print Name (if you are not the patient): | | | | | | | | |

On receipt of your application form we may contact you for further information and in some cases a clinician may contact you prior to an appointment being made