

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	<input type="checkbox"/>	White/Black Caribbean	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Irish	<input type="checkbox"/>	White/Black African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	African	<input type="checkbox"/>	Any Other Ethnic Group	<input type="checkbox"/>
Any Other White Background	<input type="checkbox"/>	White/Asian	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Any Other Black Background	<input type="checkbox"/>	Decline To State	<input type="checkbox"/>
	<input type="checkbox"/>	Any Other Mixed Background	<input type="checkbox"/>	Any Other Asian Background	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

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