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| **HOW DO I APPLY?** | |
| You can self-refer to the podiatry department by completing this application form and sending it to the address below. Please include as much information as possible in order for us to prioritise your referral and book an appropriate appointment (face to face or telephone). If you need help completing the form please contact the Podiatry Office on the number below.  **If possible please attach a photograph of your current foot problem**. | |
| **Northern Podiatry Services**  Barnstaple Health Centre, Vicarage Street  Barnstaple EX32 7BH | **Eastern Podiatry Services**  Newcourt House, Newcourt Drive, Old Rydon Lane  Exeter EX2 7JQ |
| Alternatively, you can email it to **Northern services**:  [rduh.podiatry@nhs.net](mailto:rduh.podiatry@nhs.net)  **01271 341509** (Monday to Friday 0900 – 1600) | Alternatively, you can email it to **Eastern services**:  [rduh.podiatryappointments-eastern@nhs.net](mailto:rduh.podiatryappointments-eastern@nhs.net)  **0345 266 7772** (Monday to Friday 0900 – 1600) |

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| **PERSONAL DETAILS** | | | | | | | | | | | | | |
| Name: Mr/Mrs/Miss/Ms | | | | | Date of Birth: .........../.............. /............. | | | | | | | | |
| NHS No. (if known): | | | | | | | | |
| Address:    Post Code: | | | | | Mobile: | | | | | | | | |
| Daytime contact number: | | | | | | | | |
| Email: | | | | | | | | |
| Please advise on your preferred contact method? (Please circle): Mobile Daytime contact number Email | | | | | | | | | | | | | |
| Name of your GP, Surgery name, address and telephone number: | | | | | | | | | | | | | |
| **REASON FOR REFERRAL (please note we do not provide simple nail cutting)** | | | | | | | | | | | | | |
| **Which of the following affects you at present? Please tick all the relevant boxes and give more detail below** | | | | | | | | | | | | | |
| Foot ulcer/wound |  | Amputation |  | Corn/callus | |  | Foot pain | | | |  | Re-issue of orthotics (please attach photo of existing orthotics) |  |
| Black/dark area |  | Infection |  | Ingrowing nail | |  | Foot deformity | | | |  |
| Further details: | | | | | | | | | | | | | |  |  |  |
| **Please indicate on the diagram below which areas are causing you pain or discomfort and level of pain:**    Right Foot Top Right Foot Sole Left Foot Sole Left Foot Top  **Pain score (please circle) 0 1 2 3 4 5 6 7 8 9 10** (0 = no pain, 10 = severe pain) | | | | | | | | | | | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | |
| For safe effective care it is important that we have a complete picture of your health, past and present.  Please tick and complete in dark inkif any of the following apply to you: | | | | | | | | | | | | | |
| **Health problem:** | | | | | | | | **Yes** | **No** | **Details:** | | | |
| Allergies e.g. - Penicillin/ iodine | | | | | | | |  |  |  | | | |
| Diabetes Mellitus  At your last annual foot check, what was your diabetic foot risk?  Have you previously had an amputation or charcot foot? | | | | | | | |  |  | Type: | | | |
| Severe renal/kidney disease or on dialysis | | | | | | | |  |  |  | | | |
| Heart disease or respiratory disease | | | | | | | |  |  |  | | | |
| Stroke/TIA (mini stroke) | | | | | | | |  |  |  | | | |
| Neurological disorder | | | | | | | |  |  |  | | | |
| Inflammatory Arthritis e.g. Rheumatoid | | | | | | | |  |  |  | | | |
| Peripheral Vascular Disease (PVD)/ Lymphoedema | | | | | | | |  |  |  | | | |
| Previous operations affecting feet or legs | | | | | | | |  |  |  | | | |
| Immunosuppressant medication or current cancer therapy | | | | | | | |  |  |  | | | |
| Pregnant or breast feeding | | | | | | | |  |  |  | | | |
| Communication difficulties  If yes, would you benefit from additional support? In what way? | | | | | | | |  |  |  | | | |
| Neurodiversity i.e. autism If yes, would you benefit from additional support? In what way? | | | | | | | |  |  |  | | | |
| Other relevant medical information | | | | | | | |  |  |  | | | |
| **MEDICATION** | | | | | | | | | | | | | |
| Please list all your current medication or attach a copy of your current prescription: | | | | | | | | | | | | | |
| Is a translator required? Yes No Please specify: | | | | | | | | | | | | | |
| **Applicant Name:** ..................................................................................................................................................  **Date:** .................................................. **Signature:** .................................................................................  If you are the applicant’s representative please complete below and state why it has been necessary for you to fill in the form and not the patient:  **Name:** ...............................................................................................................................................  **Date:** .................................................. **Signature:** ................................................................................  **Contact Tel:** ........................................ **Relationship to applicant:** ............................................................  **Any other information:** ....................................................................................................................................  ***We will contact you with an outcome of your referral.*** | | | | | | | | | | | | | |