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| **Podiatry Service****By making this referral the patient agrees to receive text and email messages about their referral, appointments and management to the mobile phone number and email address listed below.** |
| **GENERAL REFERRAL INFORMATION** |
| REFERRAL DATE |  |
| DATE OF BIRTH |  | NHS NO. |  |
| FAMILY NAME |  | GIVEN NAME |  |
| PREVIOUS FAMILY NAME |  | TITLE |  | SEX |  |
| ADDRESS |  | DAYTIME TEL NO. |  |
| MOBILE NUMBER |  |
| EMAIL ADDRESS |  |
| INTERPRETER NEEDED LANGUAGE | [ ]  Yes [ ]  No  |
| ANY CONDITION / ILLNESS THAT MAY AFFECT MENTAL CAPACITY TO CONSENT TO ASSESSMENT / TREATMENT? | [ ]  Yes [ ]  No (PLEASE INCLUDE DETAILS BELOW) | IS THE PATIENT AWARE OF THIS REFERRAL? | [ ]  Yes [ ]  No  |
| IS THE PATIENT A CARER? | [ ]  Yes [ ]  No  |
| ANY RELEVANT SAFEGUARDING INFORMATION? | [ ]  Yes [ ]  No (PLEASE INCLUDE DETAILS BELOW) | CHILDREN SAFEGUARDINGIS THE CHILD/UNBORN CHILD, SUBJECT OF A CHILD PROTECTION PLAN?IS THE CHILD LOOKED AFTER? (By Local Authority)DOES THE CHILD HAVE A SOCIAL WORKER? | [ ]  Yes [ ]  No [ ]  N/A[ ]  Yes [ ]  No [ ]  N/A[ ]  Yes [ ]  No [ ]  N/A |
| FOR 14-25 YEAR OLDS, IS THIS REFERRAL PART OF TRANSITION PLANNING TO ADULT SERVICES? | [ ]  Yes [ ]  No  |
| REFERRING CLINICIAN |  | GP PRACTICE / REFERRING ORGANISATION OR DEPARTMENT |  |
| [ ]  MILITARY SERVICE PERSON [ ]  MILITARY VETERAN [ ]  MEMBER OF MILITARY FAMILY   |
| **SERVICE REFERRAL DETAILS** |
| **Please indicate Podiatric need:** |
| **Routine / High Risk Foot** [ ] **Currently ulcerated?** [ ] Yes [ ] No | **Ingrowing toenail** [ ] **Open wound/exudate?** [ ] Yes [ ] No**Currently infected?**[ ] Yes [ ] No**On antibiotics?**[ ] Yes [ ] No | **Musculoskeletal Need** [ ] **(ie. MSK foot pain, Gait analysis, foot orthoses assessments etc)** |
| **Reason for referral: Please include photos / upload to SystmOne, wherever possible, and include as much detail as possible to ensure accurate triage****\*mandatory field**      |
| **Other relevant history (ie. Imaging, operations, previous investigations/referrals) if applicable:** |
| **Is the patient seen by other services for this problem? (ie. Community team, Physiotherapy etc) State which:** |       |
| **Most recent HbA1c result if applicable** |  |
| **Date and result of latest foot health risk assessment (if diabetic)?** |  |
| **MEDICAL HISTORY:**  |  |
| **MEDICATION:** |

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| **PLEASE ENSURE THAT ALL FIELDS ARE COMPLETED CORRECTLY.****INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED TO THE REFERRER** |

FORM SHOULD BE SENT VIA E-REFERRAL - whc.adminpodiatry@nhs.net