|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 SAFEGUARDING  IS 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:** | | | |  |  | | --- | --- | |  |  | |  |  | | | | | | | | |
| **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](mailto:whc.adminpodiatry@nhs.net)