**NHS Highland Podiatry Service DOES NOT undertake nail care**

Each patient will be assessed so an individually tailored management plan can be agreed.

Treatment may not be given during this initial assessment.

**Please return completed forms to**

**Please return completed electronic forms to:**

nhsh.southandmidpodiatry@nhs.scot

**(Please mark e-mail “new referral”)**

**Incomplete forms will be returned which will delay any issuing of an appointment**

|  |  |  |  |
| --- | --- | --- | --- |
| **First name:** |  | **DOB:** |  |
| **Surname:** |  | **Title** |  |
| **Address:** |  | **Home** |  |
| **Mobile** |  |
| **Post Code** |  | **e-mail** |  |
| **GP Practice** |  |
|  |
| **Reason for referral.** *Please describe as fully as possible the problem you have with your feet. This section is important in enabling us to assess the urgency of your referral.* |
|    |
| **How do you think Podiatry can help?** |
|  |
| **How long have you had this problem?**Less than 2 wks [ ]  2-12 weeks [ ]  3-12 months [ ]  Over 1 year [ ]  |
| Is the problem area red? | Yes [ ]  | No[ ]  |
| Is the problem area swollen? | Yes [ ]  | No[ ]  |
| Is the problem area bleeding / discharging / weeping? | Yes [ ]  | No[ ]  |
| Are you currently taking, (or have recently taken), antibiotics for this problem? | Yes [ ]  | No[ ]  |
| Have you had treatment for this problem before? Yes [ ]  No [ ] If Yes please state where and by whom.  |

|  |
| --- |
| **Is the problem causing pain?** Yes **□** *(use X to indicate pain level on scale below)* No **□**  |
| **No Pain** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | 4[ ]  | 5[ ]  | 6[ ]  | 7[ ]  | 8[ ]  | 9[ ]  | 10[ ]  | **Worst Pain Ever** |

|  |  |
| --- | --- |
| **Do you have Diabetes?** | Yes [ ]  No [ ]  |
| ***If YES*** please tick the box that represents your diabetes foot risk category at your last foot check up. Low Risk [ ]  Moderate Risk [ ]  High Risk [ ]  Active Foot Disease [ ]  Don’t Know [ ] I’ve never had my feet checked [ ]  |
| **Please list all other medical conditions**  |
|  |  If **NONE** *please tick this box* [ ]  |
| **Please list all current medications *(attach a prescription tear-off slip if possible)*** |
|  |  If **NONE** *please tick this box* [ ]  |
| **Allergies?**  |  Yes [ ]   *specify*  No [ ]  |

|  |  |
| --- | --- |
| **Appointment Support:**   | If you require communication support please specify below |
| British Sign Language interpreter [ ]  Language interpreter [ ]  (Language ) Other **□** *specify* |
| **Do you have a physical disability?**  |  Yes [ ]  *Specify*  No [ ]  |
|  |
| **Emergency Contact** |
| **Name**  |       | **Tel. no.** |  |
|  |
| **Print name:**       | **Date:** |
| **Relationship if completing on behalf of patient:** |       |

 **Please note incomplete forms will be returned which will delay any issuing of an appointment**