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| **REFERRER DETAILS** | **DATE OF REFERRAL:** |
| **REFERRER NAME:****REFERRER DESIGNATION:** | **REGISTERED GP AND SURGERY:** |
| **PATIENT DETAILS:** | **NHS NUMBER:** | **DOB:** |
| **TITLE** | **FIRST NAME:** | **SURNAME:** |
| **ADDRESS:** | **HOME TELEPHONE:****MOBILE TELEPHONE:** |
| **ETHNICITY:** | **RELIGION:** | **LANGUAGE SPOKEN:** |
| **NEXT OF KIN:****TELEPHONE:** | **SEE AT CLINIC:** **HOUSE BOUND: YES NO****DOES PATIENT NEED TRANSPORT:YES NO****TO BE ELIGIBLE FOR A HOME VISIT PATIENT MUST MEET ONE OF THE FOLLOWING CRITERIA:****• Bed or Chair bound 24/7** **• Require hoisting in order to be moved to travel** **• Deemed too clinically ill to be expected to travel** |
| **REFERRAL:** **ROUTINE****SOON****URGENT****FOOT ULCERATION OR FOOT WOUND**  |
| **REFERRAL:** |
| **HISTORY OF CURRENT PROBLEM:****IF REFERRAL IS DUE TO A MUSCULOSKELETAL (MSK) ISSUE (MSK FOOT/ANKLE PAIN, DEFORMITY, TENDINOPATHY, FASCIITIS, FLAT FEET ECT) IS THE PATIENT SYMPTOMATIC:**  |
| **EXAMINATION FINDINGS** (IF PATIENT HAS DIABETES, MUST INCLUDE FOOT RISK STATUS, NEUROVASCULAR ASSESSMENT RESULTS AND HBA1C):**PLEASE ATTACH RECENT RADIOLOGY/BLOOD/PATHOLOGY REPORTS** | **DIABETES FOOT RISK STATUS:****LOW****MODERATE** **HIGH****HBA1C:**  |
| **REASON FOR REFEERAL TO PODIATRY SERVICE:** |
| **MEDICAL HISTORY:** | **CURRENT MEDICATIONS:** |
| **MAIN PODIATRY LINE  03330 153 482****EMERGENCY LINE   01279 827841****SEND REFERRALS VIA EMAIL:** **epunft.podiatry@nhs.net** |
| **N.B INCOMPLETE FORMS AND THOSE NOT MEETING OUR ACCESS CRITERIA WILL BE RETURNED** |