

**Application for podiatry/chiropody treatment**

NHS Podiatry (Chiropody) is a **high-risk** service, which is ***only***available to people with an active foot problem along with a medical condition which adversely affects their feet. Eligibility is *not* related to age. The following conditions meet our criteria for treatment eligibility:

* Active foot problems, for example, ulcers, corns and callous in patients that have a health problem that puts them at risk such as diabetes, circulatory disorders, daily steroid tablets, current chemotherapy, neurological problems, inflammatory arthritis for example rheumatoidarthritis and ulcers**.**

**We do not provide a toenail cutting service**

If you feel you have a condition that qualifies you for a NHS assessment, please complete and submit the form. **It is important that you complete every section otherwise your application will be rejected.**

|  |  |
| --- | --- |
| Date of Referral: | NHS Number: |
|  | |
| **Patient Details** | |
| Forename: | Surname: |
| Address and Postcode: | |
| Date of Birth: | Gender: |
| Home Telephone: | Mobile Telephone: |
| Email address: | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GP Details** | | | | | |
| Registered GP: | Telephone: | | | | |
| GP Practice: | Fax: | | | | |
| Have you received NHS Podiatry/Chiropody previously? | |  | Yes |  | No |
| Have you seen any other health professional regarding the problem you are seeking treatment for? | |  |  |  |  |
| If yes, when: | and where: | | | | |
| **\*\*\* Please supply an image of the problem that requires treatment \*\*\*** | | | | | |
| What problem do you have that you require a Podiatry appointment for? How long has your foot problem been there and what measures have you already tried? | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **Medical History** | | | | | |
|  | Allergies |  | Diabetes |  | Kidney Disease |
|  | Rheumatoid Arthritis |  | Poor Circulation |  | Registered Blind |
|  | Heart/Stroke |  | Neurological Disorder |  | Active Cancer |
|  | Hepatitis |  | Other | Nil | |
| If yes please give details- | | | | | |

**Medication**: Please attach a list

**Patient equality and diversity information**

Please complete to help us ensure that the services we provide are fair, equal and inclusive.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **□** British or Mixed British | □ Irish | □ Other White Background | □ Other Mixed Background | □ Other Black Background |
| □ Other Asian Background | □ Other Ethnic Category |  |  |  |

|  |  |
| --- | --- |
| Main spoken language |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Disabilities (please indicate relevance to this referral)** | | | | | |
|  | Learning disability |  | Physical impairment |  | Sensory impairment |
|  | Mental Health condition |  | Longstanding illness |  | Other |
| Additional Information: | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| How would you like to have confirmation of receipt of referral?  **(please give details)** | □ Letter | □ Telephone | □ Text/Mobile | □ Email |

Do you give permission for EPUT Podiatry Services to share your care? This means your records will be shared with your GP and/or other departments involved in your health care.

Yes □ **No**  □

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return completed forms to:**

EPUT Podiatry Services

Ashingdon House

Rochford Hospital

Union Lane

Rochford

Essex SS4 1RB

**E-mail Address:** epunft.southeastpodiatry@nhs.net