

**APPLICATION FOR PODIATRY BIOMECHANICS/ MUSCULOSKELETAL TREATMENT**

Biomechanics means the assessment of the way that the joints, tendons and muscles of the legs and feet move and interact individually and with each other. The service is available to people over 12 years of age who can attend the clinic and are suffering from mechanical pain or disability whilst walking or standing due to ankle, heel, foot, knee or lower back pain.

**We are unable to treat: toe deformity, corns or callous on toes, Morton’s neuroma, ganglion’s or fibroma.**

If you feel you have a condition that qualifies you for a NHS biomechanics 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.

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| --- | --- | --- | --- | --- |
| **□** 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: | | | | | |

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| --- | --- | --- | --- | --- |
| 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