**NHS No:**

**Trafford podiatry service**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Application form for community podiatry assessment (2015)** | | | | | | | | | | | | | | | | |
| **ALL INCOMPLETE REFERRALS WILL BE RETURNED** | | | | | | | | | | | | | | | | |
| **Referral Guidelines – Please read before completing this form**  The NHS Podiatry service is a medical service. Treatment will only be given to patients with a medical condition affecting their feet, those requiring nail surgery, or those with a foot disorder which is assessed by the podiatrist as requiring intervention.  We are unable to provide treatment for simple nail cutting, footwear related corns and callus, and non-painful foot conditions unless this would lead to a critical foot problem if not seen by a podiatrist. | | | | | | | | | | | | | | | | |
| **Details of person completing this form:** | | | | | | | | | | | | | | | | |
| **Name:** |  | | | **Designation: e.g. self, GP, DN, PN etc** | | | |  | | | | **Date:** | |  | | |
| **Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(If the applicant is requesting a home visit this form must be completed by a medical professional, please see over page)** | | | | | | | | | | | | | | | | |
| **PATIENT DETAILS (please PRINT)** | | | | | | | | | | | | | | | | |
| **Surname** | |  | | | | **Forename** | | |  | | | | **Gender** | | | M / F |
| **Address and postcode:** | |  | | | | | | | | | | | | | | |
| **Date of birth:** | |  | | | **GP name:** | | | | | |  | | | | | |
| **Tel no:** | |  | | | **GP address:** | | | | | |  | | | | | |
| **Mobile no:** | |  | | |
| **Emergency contact name**  **& number:** | | | | |  | | | | | | **Relationship:** | | | |  | |
| **Have you been diagnosed with any of the following conditions: Please tick correct box** | | | | | | | | | | | | | | | | |
| **Diabetes** | | | Yes / No | | | **Managed by:** | | | | GP / Hospital  **Name of consultant**: | | | | | | |
| **Rheumatoid Arthritis** | | | Yes / No | | | **Managed by:** | | | | GP / Hospital  **Name of consultant:** | | | | | | |
| **Peripheral Vascular Disease** | | | Yes / No | | | **Managed by:** | | | | GP / Hospital  **Name of consultant**: | | | | | | |
| **Any other significant medical condition for which you attend your GP / Hospital – please specify:** | | | | | |  | | | | | | | | | | |
| **What problems are you having with your feet?**  **Please describe your foot problem:** | | | | | | |  | | | | | | | | | |
| **How does this impact your day to day activities?**  **Please explain:** | | | | | | |  | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Please record the current level of pain from your feet:** | | | **1 2 3 4 5 6 7 8 9 10**  (1 = insignificant 10 = extreme) | | | | |
| **Please list all your current medication, or attach a copy of your current prescription list:** | | |  | | | | |
| **Have you ever had a foot ulcer or amputation?** | | Yes / No | **Please give details**: | | | | |
| **Are you able to manage your own routine foot care? (Please tick most appropriate)** | | | | | Yes I am able to manage my own routine foot care | |  |
| I have a carer or family member who assists me with foot care | |  |
| I have no carer or family member who can assist me with foot care | |  |
| **If you are requesting a home visit and are known to be housebound with your GP surgery you must obtain below the signature of a member of your GP practice team e.g. GP, practice nurse:** | | | | | | |
|  | | |  | | **Name** | |
|  | | **Signature** | |
|  | | **Designation** | |

**Choice of Clinic Location:** (please tick the appropriate box)

Please identify which clinic is most convenient for you to attend for assessment:

🞎 Chapel Road Clinic, Sale *(Tuesday evenings available – selected clinic types only)*

🞎 Delamere Centre, Stretford (bariatric chair available)

🞎 Limelight community Health Centre, Old Trafford

🞎 Partington Health Centre, Partington

🞎 Timperley Health Centre, Timperley

🞎 Woodsend Clinic, Flixton

**Please return the completed form to:**

**Podiatry Referrals**

|  |  |
| --- | --- |
| **OFFICE USE ONLY** |  |
| Date: |  |
| Triage Category: |  |

**Single Point of Access**

**Crossgate House**

**Cross Street**

**SALE**

**M33 7FT or Email tspoa1@nhs.net**

* The information you have provided will be used to assess whether you are eligible for an NHS Podiatry Assessment.
* Each application will be triaged by a Podiatrist. You may be contacted by telephone to gain further information regarding your application, or to offer appropriate health education advice if you are not eligible for assessment.
* If you are eligible to access the service we will contact you with an assessment appointment.
* At assessment, the podiatrist may:

1. Offer you advice and no further treatment, at which point you will be discharged from the service.
2. Arrange a course of treatment, after which point you will be reviewed and either discharged or offered further treatment.