Box for Barcode

**NHS Tayside Podiatry Assessment – Self Referral Form**

**Please complete ALL sections of this form by filling in the boxes and answering all of the questions. INCOMPLETE REFERRAL FORMS WILL BE RETURNED.**

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| **Personal Information** |
| Title.......... Forename....................................... Surname..................................Date of Birth.......................................Address................................................................................................................................................................................................................................................................................................................................................................................................................................................ Postcode.......................................................Tel no (including STD code)........................................ Mobile no..............................................GP............................................... GP Practice.......................................................................Emergency contact or carer contact.Name.................................................................. Tel no..........................................................Address......................................................................................................................................Do you have a carer to help with your daily needs? Yes No Do you require a translator/interpreter Yes No If YES Language............................................................. |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Reason for Referral – complete relevant boxes below** | Yes | No |
| 1 | A skin complaint? |  |  |
| 2 | A nail complaint? |  |  |
| 3 | A foot deformity? |  |  |
| 4 | Muscle or joint pain in the foot? |  |  |
| 5 | Do you wish surgical removal of a toenail? |  |  |
| 6 | Is your foot condition discharging or weeping? |  |  |
| 7 | Are you currently taking antibiotics for the foot condition that you are contacting the Podiatry Service about?If the answer is YES, for how long? ...................weeks. |  |  |

|  |  |
| --- | --- |
|  | **Medical Information and Medication** |
| 1 | Do you have Diabetes? Yes NoIf YES, please tick the box that represents your foot risk score. Low Risk Moderate Risk High Risk High Risk in remission Active Foot Disease If you are unsure of this, your GP surgery will be able to confirm your score.  |
| 2 | Please list any other medical conditions that you are currently being treated for or have been treated for in the past. |
| 3 | Please list all prescribed medication that you are currently taking.(or attach list) |
| 4 | Please give a description of your foot problem and/or reason for requesting assistance. **Please note Podiatry is not a personal nail cutting service** |

Applicant signature................................................................. Date......................................

**Please note that self-referrals will only be accepted if the person requesting assistance has the capacity to self refer, or is being made on behalf of a child. In all other circumstances, a separate referral must be made by a healthcare professional.**