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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**](mailto:epunft.podiatry@nhs.net) | | | | | |
| **N.B INCOMPLETE FORMS AND THOSE NOT MEETING OUR ACCESS CRITERIA WILL BE RETURNED** | | | | | |