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**EPUT Podiatry West Essex Patient Self-Referral Nail surgery form**

Referrals to EPUT for Ingrowing Toenails will only be accepted for patients with moderate to severe symptoms where primary care management has been tried and failed.

To be eligible for nail surgery within the community Podiatry service you must have one or more of the following:

Moderate-Severe Symptoms include:

* Increased pain and inflammation of the toe
* Discharge
* Bleeding
* Recurrent Infection
* Severe and disabling pain
* Substantial erythema (redness)  and inflammation
* Infection
* Misshapen or curved nail causing pain

If you feel you have an ingrowing toenail and one or more of the statements above is true, you could qualify for assessment, please complete this form.

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| Please provide a clear reason for referral, please state which statements above are true, the location, duration, symptoms and any other relevant information:  (Please continue on back of sheet or below if necessary) | | | | | |
| What measures have you taken to resolve the ingrowing toe nail? | | | | | |
| Please note, nail surgery will be under taken with a local anaesthetic, are you happy to proceed with this? | | | | | |
| Please be aware all nail surgery referrals must be completed with photos of the ingrowing toenail. If no photos are received your referral will be declined. | | | | | |
| GENDER: | FIRST NAME: | | | SURNAME: | |
| TITLE: | NHS NUMBER: | | | DOB: | |
| ETHNICITY: | | | RELIGION: | LANGUAGE SPOKEN: | |
| ADDRESS:  POST CODE: | | | | | HOME TELEPHONE:  MOBILE TELEPHONE: |
| GP NAME:  GP SURERY ADDRESS: | | | | | |
| NEXT OF KIN NAME: | | NEXT OF KIN TELEPHONE: | | DATE OF COMPLETEING REFERRAL FORM: | |
| MEDICAL HISTORY: | | | | | CURRENT MEDICATIONS: |
| Do you have diabetes? If so, please state which type and what your latest HbA1c blood test result is. (You can find this out from your GP surgery) | | | | | |
| Are you currently under the care of any other medical team? If yes, please provide details: | | | | | |
| Have you received NHS Podiatry/Chiropody previously? Yes No  If yes, when and where: | | | | | |
| How would you like to have confirmation of receipt of referral? (please tick)  □ Letter □ Telephone □ Text/Mobile | | | | | |
| Send you referral by email to: [epunft.podiatry@nhs.net](mailto:epunft.podiatry@nhs.net)  By post: Podiatry Department, St Margarets Hospital, The Plain, Epping, Essex, CM16 6TN  If sending by email you may also attach a photo to support your referral  Podiatry admin team: 03330 153 482 | | | | | |
| N.B PLEASE ENSURE ALL SECTIONS OF THIS FORM ARE COMPLETED ANY INCOMPLETE FORMS AND THOSE NOT MEETING OUR ACCESS CRITERIA WILL BE RETURNED | | | | | |