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| Hertfordshire Podiatry Self Referral Form  Sandridge Gate Business Centre, Ronsons Way, St. Albans, AL4 9XR  Head office: 01727 732004 Email: [podiatryhct@nhs.net](mailto:podiatryhct@nhs.net) | | | | | |
| 1. Patient Details | | | | | |
| Name: | | | Date of Birth: | | |
| NHS No: | | | Address:  Post Code: | | |
| Home Telephone No:  Mobile Telephone No:  Email Address: | | |
| Emergency Contact/Next of Kin  Name:  Address:  Post Code:  Telephone No:  Relationship to patient: | | | GP Name:  Surgery Address:  Post Code:  Telephone No:  Fax No: | | |
| 1. **Special Requirements:** Please tick | | | | | Yes |
| Interpreter | | | | |  |
| Wheelchair user If Yes, please state if you can/cannot transfer to a treatment couch unaided | | | | |  |
| On the Learning Disabilities Register | | | | |  |
| **Are there any adjustments we can make for you?** If Yes, please provide details below: | | | | | |
| 1. **Please give details of your:** | | | | | |
| **Weight:** | **BMI:** | | | **Shoe Size:** | |
| *Please leave this area clear for office use* | | | | | |
| 1. **Please describe the foot problem requiring attention:** | | | | | |
| If this section is not completed the referral will be returned | | | | | |
| 1. **Do you have:** Please tick | | **Provide details** | | | |
| Diabetes | |  | | | |
| Peripheral Vascular Disease | |  | | | |
| Neuropathy | |  | | | |
| Foot deformity | |  | | | |
| Previous foot ulcer | |  | | | |
| Rheumatoid Disease (not osteo-arthritis) | |  | | | |
| Kidney Disease | |  | | | |
| Suppressed immunity | |  | | | |
| Neurological disorder | |  | | | |
| Blood borne infection | |  | | | |
| **Do you have any allergies?** If Yes, please provide details below | | | | | |
| 1. **Please provide details of any other medical history or consultant care:** | | | | | |
|  | | | | | |
| 1. **Please list all medications below, or attach a copy of the prescription** | | | | | |
| **1.** | | | **5.** | | |
| **2.** | | | **6.** | | |
| **3.** | | | **7.** | | |
| **4.** | | | **8.** | | |

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| **I confirm that the above information is correct and accurate to the best of my knowledge/consent.**  **Signature of person completing the form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**  **Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |