

|  |
| --- |
| Hertfordshire Podiatry Self Referral FormSandridge Gate Business Centre, Ronsons Way, St. Albans, AL4 9XRHead office: 01727 732004 Email: 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.** |

|  |
| --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |