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| Herts Valleys Integrated Diabetes Service – Podiatry  Self-Referral Form  Sandridge Gate Business Centre, Ronsons Way, St. Albans, AL4 9XR  Office: 01727 732073 option 1 Email: [hids.diabetes@nhs.net](mailto:hids.diabetes@nhs.net) | | | | | | |
| After receiving your application, we will either-   * review your needs and make an appointment for you if they fall within the NHS criteria * let you know that we are unable to help if your needs fall outside of the NHS criteria | | | | | | |
| 1. Patient Details | | | | | | |
| Name: Mr/Mrs/Ms/other | | Date of Birth: | | | | |
| NHS No: | | Address:  Post Code: | | | | |
| Mobile Telephone No (this will be used to send texts)  Home Telephone No:  Email Address: | |
| Emergency Contact/Next of Kin  Name:  Address:  Post Code:  Telephone No:  Relationship to patient: | | GP Name:  Surgery Address:  Post Code: | | | | |
| Please note all appointments are in a clinical site. We do not provide home visits. | | | | | | |
| 1. **Special Requirements:** Please tick if appropriate | | | | | Yes | |
| Interpreter + which language you require | | | | |  | |
| Wheelchair user: 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 list all medications below, or attach a copy of the prescription** | | | | | | |
| **1.** | | **5.** | | | | |
| **2.** | | **6.** | | | | |
| **3.** | | **7.** | | | | |
| **4.** | | **8.** | | | | |
| 1. **Please provide details of any other medical history or consultant care:** | | | | | | |
|  | | | | | | |
| **Do you have any allergies?** If Yes, please provide details below | | | | | | |
| **Are you a smoker / ex-smoker / never smoked?** | | | | | | |
| **Do you have diabetes** *(If you do not have diabetes, please ask your GP to refer you to Core Podiatry)* | Yes | |  | No | |  |
| **Do you have a current foot wound / ulcer** | Yes | |  | No | |  |
| **Are you currently taking antibiotics for a foot problem?** | Yes | |  | No | |  |
| Are your feet cold/ darker than usual/ cramp in calf when walking a short distance | Yes | |  | No | |  |
| Do you have loss of feeling in your feet | Yes | |  | No | |  |
| Have you had a foot wound / ulcer before | Yes | |  | No | |  |
| Do you have a blood borne infection | Yes | |  | No | |  |
| 1. **Please describe the foot problem requiring attention:** | | | | | | |
| Please include details of any redness, weeping, open areas, foot deformity or anything you think may be urgent.  Please include how long have you had the problem and any previous treatment received  We will not be able to accept this referral if this section is not completed | | | | | | |
| **If you are able, please include a photo of your problem when emailing the referral as this will help us decide on the urgency of your referral.** Email: [hids.diabetes@nhs.net](mailto:hids.diabetes@nhs.net) | | | | | | |
| **Name of person completing the form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**  **If completing on behalf of someone what is your relationship to them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |