**CLCH COMMUNITY PODIATRY SELF REFERRAL FORM**

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| **PLEASE NOTE:**   * For all emergency podiatry conditions please attend your local walk-in centre / A&E / or call 111 – please refer to self-referral check list. * Any patients who have no significant medical need AND are not at risk of foot wounds will not be accepted. | | | | | | | | |
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| **PLEASE COMPLETE THIS FORM IN FULL – INCOMPLETE REFERRALS WILL BE RETURNED** | | | | | | | | |
| **Do you /does the patient consent to share and access clinical records with GP?**  Y N | | | | | | | | |
| **Do you / does the patient have capacity to make decisions:** Y  N | | | | | | | | |
| **Patient Information:**  Title:  Surname:  First Name:  NHS No:  Date of Birth:  Gender:  Home address:  Postcode:  Home Telephone Number:  Mobile Number:  Email Address:  **Next of kin:**  Name:  Telephone number:  Relationship: | | | | | **GP Information:**  GP Name:  Practice:  Address:  Phone number:  Email address: | | | |
| **Ethnic Origin:**  Ethnicity:  Language:  Interpreter Required? Y  N | | | |
| **Other relevant information:**  Is the patient registered blind? Y  N  Is the patient homeless? Y  N  Is the patient housebound? Y  N  *(please note this will need to be verified via the GP record)*  Is the patient a smoker? Y  N | | | |
| **Does the patient have a support worker?** Y  N  *(Please provide as much information as possible to allow the service to contact/support the patient):* | | | | | | | | |
| **Does the patient need patient transport to access the service?** Y  N  *(Please note you will need to meet specific transport criteria to be accepted)* | | | | | | | | |
| **Please state any known allergies?** Y  N  *(Please include any allergies to local anaesthesia*): | | | | | | | | |
| **RELEVANT MEDICAL HISTORY -** *(Please put an ‘X’ in the box’s that apply)* | | | | | | | | |
| **DIABETES**  **PERIPHERAL ARTERIAL DISEASE** *(reduced circulation to your lower limbs)*  **IMMUNO-SUPPRESSION**  **RENAL DISEASE** *(e.g. on dialysis)*    **RHEUMATOID ARTHRITIS**  **INFLAMMATORY ARTHRITIS**  **CONNECTIVE TISSUE DISORDER**    **NEUROLOGICAL DISORDER** *(e.g. MS)*    **CARDIOVASCULAR DISEASE**    **NO RELEVANT SIGNIFICANT MEDICAL HISTORY**  **OTHER RELEVANT MEDICAL HISTORY** *(please state):* | | | | | | | | |
| **Medication:**  *(Please list all your current medications)* | | | | | | | | |
| **REASON FOR REFERRAL / PRESENTING FOOT COMPLAINT -** (*Please include as much information as you can) \* Patients with a red, hot, swollen foot – please attend A&E or call 111 \** | | | | | | | | |
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| **PLEASE PUT AN ‘X’ IN YES OR NO -** (*Please add more details in the right-hand side space)* | | | | | | | | |
| Open foot wound | **YES** |  | **NO** | | |  | **Site & details:** |  |
| History of foot wounds | **YES** |  | **NO** | | |  | **Site & details:** |  |
| Previous amputation | **YES** |  | **NO** | | |  | **Site & details:** |  |
| Presence of infection  *(Hot toe / foot, swelling, redness, unpleasant smell, increased pain, feeling unwell)* | **YES** |  | **NO** | | |  | **Site & details:** |  |
| Infected in-growing toenail (on antibiotics) | **YES** |  | **NO** | | |  | **Site & details:** |  |
| Chronic in-growing toenail *(previously requiring antibiotics)* | **YES** |  | **NO** | | |  | **Site & details:** |  |
| Painful nail deformity *(for total nail removal only)* | **YES** |  | **NO** | | |  | **Site & details:** |  |
| Corns and / or Calluses | **YES** |  | **NO** | | |  | **Site & details:** |  |
| Other:  *(Please provide further information about the condition):* |  | | | | | | | |
| **MUSCULOSKELETAL (MSK) PRESENTATIONS - PLEASE PUT AN ‘X’ IN THE BOX’S THAT APPLY** | | | | | | | | |
| Pain in the toes / ball of the foot  Ankle pain  Flat / high arched foot  Plantar fasciitis (heel pain)  Lower limb assessment (gait analysis)  Tendinopathies (Achilles, tendon injuries / pain)  Bunion *(if surgical opinion required, please ask your GP to refer you to Orthopaedics/Podiatric Surgery)* | | | | | | | | |
| **DATE OF REFERRAL:** | | | | **PLEASE RETURN FORM TO:** *(as a word document)*  **Brent Outer North West London, CLCH Community Podiatry Service e-mail:**  [clcht.brentspa@nhs.net](mailto:clcht.brentspa@nhs.net) | | | | |
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