

Request for Podiatry Assessment

Please complete all sections in **BLOCK CAPITALS**



Birmingham East and North

Your details	
Last name:	Title: Mr / Mrs / Miss / Ms / Other
First name:	Date of birth:
Address:	Postcode:
	Telephone number:
	Mobile number:
Preferred language: Interpreter required? Yes / No	NHS number (if known):
Your GP's details	
GP's name:	Current medication (if known):
GP's practice address:	
Your reasons for requesting assessment	
I am 18 years old and over, and have one or more of the following (tick all that apply):	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) such as chronic bronchitis <input type="checkbox"/> Coronary heart disease <input type="checkbox"/> History of falls	<input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Heart failure <input type="checkbox"/> Had a stroke or TIA ("mini-stroke") <input type="checkbox"/> Blindness or visual impairment <input type="checkbox"/> Physical disability
Please be aware that the Podiatry Service cannot provide nail cutting for people unless they have medical problems affecting their feet	
I have the following problems with my feet (please tick all that apply):	
<input type="checkbox"/> An open wound on foot <input type="checkbox"/> Hard skin or corn	<input type="checkbox"/> Ingrowing toe nail <input type="checkbox"/> Foot pain which affects my daily life
<input type="checkbox"/> Briefly describe any other problem with your feet	
<input type="checkbox"/> I have never been seen by the Podiatry Service before	<input type="checkbox"/> I was last seen by the Podiatry Service on (approximate date)
In signing this form, I give my consent for you to contact my GP for my medical information	
Signature:	Date:

Please email to: Podiatry.diary@benpct.nhs.uk

Alternatively post to: Podiatry Access Team, Stockland Green PCC, 192 Reservoir Road, Erdington, B236DJ