**NHS Highland Podiatry Service DOES NOT carry out SIMPLE nail cutting**

Each patient will be assessed so an individually tailored management plan can be agreed.

Treatment may not be given during this initial assessment.

**Please return completed forms to:**

Highland Podiatry Department, 24 Abban Street, Inverness IV2 8HH (Tel. 01463 723250)

**All sections must be completed in BLOCK CAPITALS**

**Please return completed forms to**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Information** | | | | | | | | | | | | | | | | |
| **Name:** | |  | | | | **M**  **F** | | **Date of Birth:** | | | |  | | | | |
| **Address:** | |  | | | | | | **Home** | |  | | | | | | |
| **Mobile** | |  | | | | | | |
| **Work** | |  | | | | | | |
| **Post Code** | |  | | | | **e-mail** | |  | | | | | | | | |
| **GP Practice** | | **Nairn Healthcare Group** | | | | | | **Tel No.** | | **01667 452096** | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Reason for referral** *(you can select more than one option)* | | | | | | | | | | | | | | | | |
| **Side:** Left  Right  Both | | | | | | | | | | | | | | | | |
| **Region:**  Toes  Heel  Arch  Top of Foot  Ankle  Knee  Hip  Back | | | | | | | | | | | | | | | | |
| **Structure:**  Nails  Skin  Muscle/Tendon  Joint  Other  (specify ………….………) | | | | | | | | | | | | | | | | |
| Is the problem area red? | | | | | | | | | | | | | | **Yes** | **No** | |
|  |  | |
| Is the problem area swollen? | | | | | | | | | | | | | |  |  | |
| Is the problem area bleeding / discharging / weeping? | | | | | | | | | | | | | |  |  | |
| Are you currently taking, (or have recently taken), antibiotics for this problem? | | | | | | | | | | | | | |  |  | |
| **Is there any other information you wish to add?** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| How long have you had this problem?  Less than 2 wks  2-12 weeks  3-12 months  Over 1 year | | | | | | | | | | | | | | | |
| Have you had treatment for this problem before? Yes  No  If Yes please state where and by whom. …………………………………………………….. | | | | | | | | | | | | | | | |
| **Is the problem causing pain?** Yes  *(use X to indicate pain level on scale below)* No | | | | | | | | | | | | | | | |
| **No Pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | 9 | | 10 | **Worst Pain Ever** | |

|  |  |  |
| --- | --- | --- |
| **Do you have Diabetes?** | | Yes  No |
| ***If YES*** please tick the box that represents your foot risk category at your last foot check up.  Low Risk  Moderate Risk  High Risk  Active Foot Disease  Don’t Know  I’ve never had my feet checked | | |
| **Please list all other medical conditions** | | |
| If **NONE** *please tick this box* | | |
| **Please list all CURRENT MEDICATIONS *(attach a prescription tear-off slip if possible)*** | | |
| If **NONE** *please tick this box* | | |
| **Allergies?** | Yes   *specify* No | |

|  |  |
| --- | --- |
| Is the problem preventing you from attending work / school? | Yes  No |
| Are you self employed or work for a small company (fewer than 250 people)? | Yes  No |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Appointment Support:** | | If you require communication support please specify below | | | |
| British Sign Language interpreter  Language interpreter  (language ………………….)  Other  *specify………………………………………………..………….* **None required** | | | | | |
| **Do you have a physical disability?** | | | Yes  *Specify* …………………….. No | | |
|  | | | | | |
| **Emergency Contact** | | | | | |
| **Name** |  | | | **Tel. no.** |  |
|  | | | | | |
| **Print name:** | | | | **Sign:** | |
| **Date:** | | | |
| **Relationship if signing on behalf of patient:** | | | |  | |