**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:** |  |