Community Podiatry Self Referral Form

Please return your form via email - Loth.Podiatrynpreferrals@nhs.scot

By Post: Podiatry Department, Slateford Medical Centre, 27 Gorgie Park Close, Edinburgh, EH14 1NQ

Information about you (the patient)

Name	**Date of Birth**
Address	**Telephone Number**
Post Code	**Can we leave a voice mail?** ☐ **Yes** ☐ **No**
GP Practice	**Email address**

WHERE is your main problem?

Please note we DO NOT provide routine treatment for fungal toenails, verrucae and toenail cutting

Ankle

- ☐ Front
- ☐ Back
- ☐ Inside
- ☐ Outside

Heel

- ☐ Back
- ☐ Inside
- ☐ Outside

Middle of foot

- ☐ Top
- ☐ Inside
- ☐ Outside

Front of foot

- ☐ Top
- ☐ Inside
- ☐ Outside

Toe

- ☐ Toe 1
- ☐ Toe 2
- ☐ Toe 3
- ☐ Toe 4
- ☐ Toe 5

Bottom of foot

- ☐ Toe
- ☐ Ball of foot
- ☐ Arch of foot
- ☐ Heel

WHAT is your main problem?

- ☐ Pain in your muscles/joints
- ☐ A wound/ulcer
- ☐ Ingrown toenail with broken skin
- ☐ Painful toenail
- ☐ Problem with your lower leg/knee
- ☐ Hard Skin / Corn

Please give more detail about your problem:

Are you in pain?

How often does your problem cause you pain?

☐ Never ☐ Occasionally ☐ Most of the time ☐ All the time

How bad is the pain when it does happen?

☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

Are you off work / studies / school because of this problem? ☐ Yes ☐ No

Your medical conditions/medication.

Are you on antibiotics for this problem? ☐ Yes ☐ No

Please list any diagnosed medical condition(s) and allergies you have.

Please list any medicines you currently take.

Do you give consent for us to check your medical records? ☐ Yes ☐ No

Your appointment. *Please note home visits are by GP referral only*

Has a podiatrist helped you for this problem before? ☐ Yes ☐ No
Are you able to attend a video appointment? ☐ Yes ☐ No
Are you happy to attend a student clinic? ☐ Yes ☐ No

If you require an interpreter what language do you require?

Please let us know if you require support for your appointment – e.g. wheelchair accessible venue, hearing loop or venue with bariatric equipment (if you are over 25 stone)

If you have completed this form on behalf of someone else because they do not have capacity to consent to treatment please provide your name, address and relation to the patient.