**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 |
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