Please complete in full, in BLACK ink, or it may need to be returned for further information

Return to:

REQUEST FOR COMMUNITY PODIATRY ASSESSMENT

The information given on this form will be entered onto a computer and under the terms of the DATA PROTECTION ACT 1998 will be treated in a secure and confidential manner.

ABOUT YOU – To be completed by the Patient / Referrer

Title	First Name(s)	Known as (or preferred name if different)
Surname/Family Name	NHS Number	Date of Birth DD / MM / YY
Home Address (including post code) Post Code		
Tel No (including code)	Mobile No.	
I give my consent for you to contact me by text message Yes No		
Name of Registered Doctor/Doctors Practice		

Next of Kin		Relationship
Tel No (including code)	Mobile No	Work No

ETHNIC MONITORING

To help us ensure that the service we provide is unbiased and equally accessible to everyone, we are required to record the ethnicity of the people that use our service. This information will be treated with confidentiality.

Please ✓ as appropriate

	✓	Ethnic group		✓	Ethnic group
A		White British	J		Pakistani
B		White Irish	K		Bangladeshi
C		Any Other White Background	L		Any Other Asian Background
D		White and Black Caribbean	M		Black Caribbean
E		White and Black African	N		Black African
F		White and Asian	P1		Black British
G		Any Other Mixed Background	P2		Any Other Black Background
H		Indian	R		Chinese
			S		Any Other Ethnic Group

Do you need an interpreter? Yes No

Religion/Beliefs:

COMPLETED BY – **The Patient / Referrer**

Signed by:	Contact Tel No if different to above:	Date
Print Name:	Designation:	

Name:	**Date of Birth:**

ABOUT YOUR HEALTH AND FOOT PROBLEM – To be completed by the Patient / Referrer

Do you receive treatment for any of the following: please ✓ as appropriate	Diabetes	
	Loss of sensation in feet	
	Heart Disease	
	Poor circulation	
Please specify any other medical condition that you are currently treated for or have been treated for in the past:		
Please list all medication you are currently taking: (attached additional documents if required)		
Please state if you are allergic to anything:		
Please give a description of your foot problem/reason for request. Include as much detail as you can as this will help us to offer you a suitable appointment For example: Foot assessment, Pain, swelling or discharge. How long have you had the problem? Do you have a fall or balance problem?		
Please give any other information which you feel that we should know or assistance you require to help you with your appointment		

YOUR MOBILITY – To be completed by the Patient / Referrer

Do you get out of your home for any of the following – please ✓ as appropriate					
Social	Shopping		**Appointments**	Hospital	
	Hairdressing / Barber			Doctor	
	Social Events			Dentist	
	Trips			Optician	
	Other			Other e.g. Day Centre	
What form of transport can / do you use – please ✓ as appropriate					
On your own	Car		**With Help**	Car	
	Taxi			Taxi	
	Bus /Public Transport			Bus / Public Transport	
	Walk			Walk	
	Scooter / Walking Aid			Scooter / Walking Aid	
	Community Transport			Community Transport	
Are you able to use a lift?					
Please give any other information which you feel that we should know about your mobility:					
We can provide you with information about Community Transport/Patient transport services that may be available to help you attend your appointment if you meet the criteria to receive these services					