| *For office use only* | |
|---|---|
| **Date Referral Received** | **Chi :** |

NHS Highland
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# NHS Highland Podiatry Service DOES NOT undertake nail care

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 IV3 8HH (Tel. 01463 723250)

or via e-mail – nhsh.southandmidpodiatry@nhs.scot

**Incomplete forms will be returned which will delay any issuing of an appointment**

| | | | |
|---|---|---|---|
| **First name:** | | **DOB:** | |
| **Surname:** | | **Title** | |
| **Address:** | | **Home** | |
| | | **Mobile** | |
| **Post Code** | | **e-mail** | |
| **GP Practice** | | | |

**Reason for referral.** *Please describe as fully as possible the problem you have with your feet. This section is important in enabling us to assess the urgency of your referral.*

**How do you think Podiatry can help?**

**How long have you had this problem?**

Less than 2 wks ☐ 2-12 weeks ☐ 3-12 months ☐ Over 1 year ☐

| | | |
|---|---|---|
| Is the problem area red? | Yes ☐ | No ☐ |
| Is the problem area swollen? | Yes ☐ | No ☐ |
| Is the problem area bleeding / discharging / weeping? | Yes ☐ | No ☐ |
| Are you currently taking, (or have recently taken), antibiotics for this problem? | Yes ☐ | No ☐ |

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 diabetes foot risk category at your last foot check up.<br>Low Risk ☐ Moderate Risk ☐ High Risk ☐ Active Foot Disease ☐ Don't Know ☐<br>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 ☐ |

| **Appointment Support:** | If you require communication support please specify below |
|---|---|
| British Sign Language interpreter ☐ Language interpreter ☐ (Language ) | |
| **Do you have a physical disability?** | Yes ☐ *Specify* No ☐ |

| **Emergency Contact** | | | |
|---|---|---|---|
| **Name** | | **Tel. no.** | |

| **Print name:** | **Date:** |
|---|---|
| **Relationship if completing on behalf of patient:** | |

**Please note incomplete forms will be returned which will delay any issuing of an appointment**