****

#### Office Only

Date Received……………………….

TIARA No: …………………………..

Triaged: Routine / Urgent

Clinic: ………………………………..

Appointment date: …………………

**Community Health Services**

**Please Return To:**

**Podiatry Service Call Centre**

**South Wigston Health Centre**

**80 Blaby Road, South Wigston**

**Leicester, LE18 4SE**

**Tel: 0116 2255118**

**Fax : 0116 2255122**

## APPLICATION FOR PODIATRY ASSESSMENT

BOTH FORMS AND ALL DETAILS **MUST** BE COMPLETED SO WE CAN PRIORITISE FOR URGENCY

(Incomplete applications *will* be returned)

***Please note – the Podiatry Service does NOT provide routine nail cutting unless you are classed as medically high risk e.g. High Risk Diabetic or severe circulation problems***

***Home Visits are only available if you are completely Bed or Housebound from medical conditions***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NHS NO** | | |  | | | | | | | **TITLE** (tick) | | | | MR | | MRS | | MISS | |  | | |
| **SURNAME** | | |  | | | | | | | **FORENAME** | | | |  | | | | | | | | |
| **Date of Birth** | | |  | | | | | | | **FAMILY GP**  **NAME & ADDRESS** | | | |  | | | | | | | | |
| **FULL ADDRESS** | | |  | | | | | | |
| **NEXT OF KIN/**  **CARER CONTACT** | | | | Name: | | | | | | | | |
| **POSTCODE** | | |  | | | | | | |
| Telephone: | | | | | | | | |
| **TELEPHONE** | | | ***IMPORTANT– we will ring you to book an appointment. If you do not have a telephone, please indicate N/A – an appointment will be sent in the post.*** | | | | | | | | | | | | | | | | | | | |
| **🕿 Home:** | | |  | | | | | | | **Consent to leave answer phone messages**  **Yes 🞎 No 🞎** | | | | | | | | | | | | |
| **🕿 Work:** | | |  | | | | | | | **Consent to contact at work**  **Yes 🞎 No 🞎** | | | | | | | | | | | | |
| ***Provide your mobile number and you will receive text message reminders of your appointments*** | | | | | | | | | | | | | | | | | | | | | | |
| * **Mobile:** | | |  | | | | | | | **I do not wish to receive text reminders** **🞎**  (consent assumed otherwise) | | | | | | | | | | | | |
| **Email Address:** | | |  | | | | | | | | | | | | | | | | | | | |
| (by supplying your email; we will assume we have consent to contact you in this way) | | | | | | | | | | | | | | | | | | | |
| **Do you have any special requirements / needs when being contacted, assessed or treated by Podiatry Services?** | | | | | | | | | | | | | | | | | | | | | | |
| Need an Interpreter | | | | |  | | Please state language | | | |  | | | | | | | | | | | |
| Need a Chaperone | | | | |  | | Suffer with deafness | | | |  | | Use a Wheelchair | | | | | | | |  | |
| Other needs | | | | |  | | \*Please state | | | |  | | | | | | | | | | | |
| **Referrer** | | | | | | | | | | | | | | | | | | | | | | |
| Patient |  | Carer | |  | | Consultant | |  | District Nurse | | |  | Practice Nurse | | | |  | | **INCH** | | |  |
| GP |  | AHP | |  | | DSN | |  | Other | | |  | AQP ref | | | |  | | LOROS | | |  |
| \*Please state Name of referrer if other than the patient and relationship if carer | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PODIATRY NEED**  **Please give detailed explanations of the current problem(s) you are having**  ***Please note – the Podiatry Service does NOT provide routine nail cutting***  ***Home Visits are only available if you are completely Bed or Housebound*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are you having problems with your:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Right Foot |  | Left Foot | | | |  | | | | Both Feet | | | |  | | | Toe Nails | | | | | | |  | | | Legs | | | | |  | | Back | |  | |
| **IF Nails, are they** | | Ingrowing | | | |  | | | | Thickened | | | | | |  | | | Distorted | | | | |  | | | Curly | | | | | |  |  | | | | |
| **Please explain what the problem is and indicate on the diagram below where, if on the feet or to do with the nails:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sole of Foot Top of Foot** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are you in pain?** | | | **Yes** |  | | | **No** | | | |  | | **If yes from 1 to 10 how bad is the pain?** | | | | | | | | | | | | | | | | | | | | | |  | | |
| **Please describe the pain and when it occurs e.g. when wearing certain shoes or running** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Have you got an open wound?** | | | | | | | | | **Yes** | | |  | | | **No** | | | | |  | |  | | | | | | | | | | | | | | | |
| **Do you think you have an infection (not fungal)?** | | | | | | | | | | | | | | | | | | | | **Yes** | |  | | | **No** | | |  | |  | | | | | | | |
| **If yes, please see your GP as soon as possible as you may need antibiotics.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is your problem affecting your mobility?** | | | | | | | | | | | | | | | | | | **Yes** | | | |  | | | | **No** | | |  | |  | | | | | | |
| **If Yes please explain how** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ethnic Origin:** (please tick one of the boxes below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **White British** | | | | |  | | | **Indian** | | | | | | | | | | | | |  | | **Other Asian Background** | | | | | | | | | | | | | |  |
| **White Irish** | | | | |  | | | **Pakistani** | | | | | | | | | | | | |  | | **Other Black Background** | | | | | | | | | | | | | |  |
| **White & Asian** | | | | |  | | | **Bangladeshi** | | | | | | | | | | | | |  | | **Other Mixed Background** | | | | | | | | | | | | | |  |
| **White & Black African** | | | | |  | | | **African** | | | | | | | | | | | | |  | | **Other Ethnic Background** | | | | | | | | | | | | | |  |
| **White & Black Caribbean** | | | | |  | | | **Caribbean** | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | |  |
| **Other White Background** | | | | |  | | | **Chinese** | | | | | | | | | | | | |  | | **Prefer not to State** | | | | | | | | | | | | | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signature**: |  | | **Date**: |  |
| Print Name (if you are not the patient): | |  | | |

**PLEASE NOW COMPLETE THE ATTACHED MEDICAL HISTORY FORM AND RETURN BOTH**

**Your application cannot be processed without BOTH forms**

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**Community Health Services**

## PODIATRY SERVICE MEDICAL HISTORY QUESTIONNAIRE

BOTH FORMS AND ALL DETAILS **MUST** BE COMPLETED SO WE CAN PRIORITISE FOR URGENCY

(Incomplete applications *will* be returned)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NHS NO** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **TITLE** (tick) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | MR | | | | | | | MRS | | | | | | | MISS | | | |  |
| **SURNAME** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **FORENAME** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Please answer all the questions. If you answer YES please give more detail, if you answer NO please move to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Do you have Diabetes?*** | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | | | | | | |  | | | | NO | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Don’t Know | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | |
| If Yes – what Type | | | | | | | | | | | | | | | | | | | | | | | | | Type I | | | | | | | | | | | | | | | |  | | | | Type II | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Other\* | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | |
| \*Please State: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How long have you been diabetic? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Years | | | | | | | | | | | | | | | | | | | | | | | | | | | | Recently Diagnosed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  |
| How do you control your diabetes? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Insulin | | | | | | | | | | | | | | | | | | | | |  | | | | | | | Tablets | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Both | | | | | |  | | | | | | | | | Diet | | | | | | | |  | |
| What was your last HBA1C test result? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | When was this taken? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| ***Do you have heart trouble?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | |  | | | | NO | | | | | | | | | | | | | | | | |  | | | | | | | | | **If NO please move on to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart attack | | | | | | | |  | | | | | | | | | Angina | | | | | | | | | | | | |  | | | | | | | | | | | Heart Failure | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | CHD | | | | | | | | | | | | | | | | |  | \*Other | | | | | | | | | | | |  | | | | | |  | | | | | | |
| \*Please State | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Do you have chest trouble?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | |  | | | | NO | | | | | | | | | | | | | | | | |  | | | | | | | | | | **If NO please move on to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| COPD |  | | | Asthma | | | | | | | | | | | | | | | | |  | | | | | \*Other | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*Please State | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Do you have circulation trouble?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | |  | | | | | | | | | | | | | | NO | | | | | | | | | | | | | | | |  | | | | | **If NO please move on to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Peripheral Vascular Disease (PVD) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | History of Deep Vein Thrombosis (DVT) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | Stroke | | | | | | |  | |
| Raynaud’s disease | | | | | | | | | | | | | | | | | |  | | | | | History of Chilblains | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | \*Other | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*Please State | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Do you have bone or joint trouble?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | YES | | | | | | | | | | | | | | | | | |  | | | | | | | | | NO | | | | | | | | | | | | | | | | **If NO please move on to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rheumatoid Arthritis | | | | | | | | | | | | | | | | | | | | | |  | | | | | Osteo Arthritis | | | | | | | | | | | | | | | | | | | |  | | | | | | | | Inflammatory Arthritis e.g. Psoriatic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | |
| Had any broken bones or fractures to legs or feet (please state below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | \*Other | | | | | | | | | |  | | | | | |  | | | | | | | |
| \*Please State | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Do you have Neurological problems?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | YES | | | | | | | | | | | | |  | | | | | | | | | | | NO | | | | | | | | | | | **If NO please move on to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neuropathy | | | | | | | | |  | | | | | | | | | | | Paralysis | | | | | | | | | | | | | |  | | | | | \*Other | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*Please State | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Do you have any Skin Conditions?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | YES | | | | | | | | | | | | | |  | | | | | | | | | | | | | | NO | | | | | | | | | | | **If NO please move on to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eczema | |  | | | Psoriasis | | | | | | | | | | | | | | | | | | |  | | | | | | | | \*Other | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*Please State | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Do you have Mental Health Problems?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | YES | | | | | | | | | | | | | | | | |  | | | | NO | | | | | | | | | | | | **If NO please move on to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dementia | | |  | | | | | | | Alzheimer’s | | | | | | | | | | | | | | | | | | | | | | |  | | | | \*Other | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*Please State | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Do you have any Allergies?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | YES | | | | | | | | | |  | | | | | | | | | | NO | | | | | | | | | | | | | | | | | | **If NO please move on to next question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Antibiotics (Please state which ones below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | Plasters | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | Latex / rubber | | | | | | | | | | | | | |  | | | | | | \*Other | | | | | |  | |  | | |
| \*Please State | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please Turn Over** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Are you taking any of the following medication?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Drugs to thin your blood e.g. Warfarin or Aspirin\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | YES | | | | | | | | | | | |  | | | | | | | | NO | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| \*If YES what are you taking? | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Beta Blockers e.g. Bisoprolol | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | Statins e.g. Simvastatin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | GTN | | | | | | |  | | | | Inhalers | | | | | | | | | | | |  | |  | | | |
| Any other type of medication\* | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | YES | | | | | | | | | |  | | | | | | | | | NO | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*If YES then please list: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ***Have you had any Operations to the following areas? (Please tick all that apply)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Foot or Feet | | | | | |  | | | | | | | | | | | | | Ankle(s) | | | | | | | | | |  | | | | | | Leg(s) | | | | | | | | | | | | |  | | | | | | | | | | | Hip(s) | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Back | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | | |
| If you have ticked any of the above, please describe what you have had done, which foot / leg, where and why? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please list any other operations you have had that you may consider relevant: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ***Please provide any other information that you feel might be relevant to us with regards your application for Podiatry Assessment:*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**Please Return Both Forms To:**

**Podiatry Service Call Centre**

**South Wigston Health Centre**

**80 Blaby Road, South Wigston**

**Leicester, LE18 4SE**

**Tel: 0116 2255118**

**Fax : 0116 2255122**

**Lines Open Mon – Fri 9am – 4pm**

Leicestershire Partnership Trust

Community Health Services Division