****

#### 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 |
|  |
|  |

|  |
| --- |
| **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: |
|  |
| ***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? |
|  |
| Please list any other operations you have had that you may consider relevant: |
|  |
| ***Please provide any other information that you feel might be relevant to us with regards your application for Podiatry Assessment:*** |
|  |

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**Leicester, LE18 4SE**

**Tel: 0116 2255118**

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**Lines Open Mon – Fri 9am – 4pm**

Leicestershire Partnership Trust

Community Health Services Division