PODIATRY DEPARTMENT

**Self – referral Form**

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| Please read the eligibility criteria before completing the self-referral form. This will provide you with information on accessing the Podiatry service as well as options for self management of your foot condition. Upon completion of the form, please post or email it to the following:  Podiatry Department  Outpatients A  Balfour Hospital  Foreland Road  Kirkwall  KW15 1BH  [ork.podiatry@nhs.scot](mailto:ork.podiatry@nhs.scot) | | | |
| Patient Details | | | |
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| Patients Name: | | | |
| Community Health Index (CHI) If known: | | | |
| Date of Birth (DD/MM/YY): | | | |
| Address: | | | |
| Postcode: | **Telephone number:** | | |
| E-mail address: | **Mobile Number:** | | |
| GP details: | **Next of Kin details:** | | |
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| Medical Information | | | |
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| Do you or have you ever had a history of any of the following medical conditions? (Tick all that apply) | | | |
| * Diabetes (Moderate/High risk) * Advanced peripheral vascular disease (Very Poor Circulation) * Neuropathy (Altered or loss of sensation in the lower limb) * Inflammatory joint disease (Rheumatological) | | * Neurological disorder affecting the lower limb (Stroke, MS, MND) * Immunosuppressed/immunocompromised * Advanced chronic kidney disease * Amputation involving the lower limb (non-traumatic) * Dermatology (Eczema/psoriasis) | |
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| Podiatric Need | | | |
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| Please refer to the eligibility criteria before making your selection. (Tick all that apply) | | | |
| * Active foot infection or ulcer * Charcot’s foot * Ingrowing toenail (Infected or inflamed) * Painful corns or callous (with medical need) | | | * Joint/soft tissue pain * Biomechanical/Gait assessment * Verrucae (where conservative treatments have failed) |

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| Brief description (Affected area/how problem arose) | | | | | |
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| How long have you had this problem? | | | | | |
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| Do you have any mobility concerns? (Use of a walking aid/ wheelchair or bed bound) | | | | | |
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| Consent to the request further medical information if required? | | | * **Yes** | | * **No** |
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| I have read and accepted the eligibility criteria | | | * **Yes** | | * **No** |
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| Signed:  Print Name:  Date: | | **If patient representative, please state your relationship (parent, guardian, next of kin, carer):** | | | |
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| Referral Recieved: |  | **Referral Completed:** | |  | |