


<i>For office use only</i>		 NHS Highland Location code
MPI	<i>CH 123456789</i>	
Urgent / Routine / MSK		
Date referral received		

NHS Highland Podiatry Service DOES NOT carry out SIMPLE nail cutting

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:

Podiatry Department, Jeanie Deans Centre, 93 East King Street, Helensburgh G84 7BU

All sections must be completed in BLOCK CAPITALS

Personal Information			
Name:		M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth:
Address:			Home
			Mobile
			Work
Post Code		e-mail	
GP Practice		Tel No.	

Reason for referral <i>(you can select more than one option)</i>		
Side:	Left <input type="checkbox"/>	Right <input type="checkbox"/> Both <input type="checkbox"/>
Region:	Toes <input type="checkbox"/> Heel <input type="checkbox"/> Arch <input type="checkbox"/> Top of Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Back <input type="checkbox"/>	
Structure:	Nails <input type="checkbox"/> Skin <input type="checkbox"/> muscle/Tendon <input type="checkbox"/> Joint <input type="checkbox"/> Other <input type="checkbox"/> (specify	
Is the problem area red?	Yes	No
Is the problem area swollen?		
Is the problem area bleeding / discharging / weeping?		
Are you currently taking, (or have recently taken), antibiotics for this problem?		
Is there any other information you wish to add?		

How long have you had this problem?
 Less than 2 wks 2-12 weeks 3-12 months Over 1 year

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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Worst Pain Ever
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Do you have Diabetes? Yes No

If YES please tick the box that represents your foot risk category at your last foot check up.

Low Risk Moderate Risk High Risk Active Foot Disease Don't Know

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

Is the problem preventing you from attending work / school? Yes No

Are you self employed or work for a small company (fewer than 250 people)? Yes No

Appointment Support: If you require communication support please specify below

British Sign Language interpreter Language interpreter (language)

Other specify..... **None required**

Do you have a physical disability? Yes Specify No

Emergency Contact

Name		Tel. no.	
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Print name:	Sign:
Date:	
Relationship if signing on behalf of patient:	

Please note incomplete forms will be returned which may result in a delay in issuing an appointment