Request for Podiatry Assessment (Self-Referral)

To be completed and submitted via E-mail attachment to LHNT.LCHSCAB@nhs.net or post to Podiatry Administration, Newland Clinic, 34 Newland, Lincoln, LN1 1XP.

For information Governance reasons the Podiatry service does not accept referrals via Fax.

When the completed form is received, a member of the podiatry team will decide its urgency. We can only do this using the information on this form, so please ensure that you have provided as much detail as possible. Please use black ink, print clearly and avoid using abbreviations. Incomplete forms will be returned.

The Podiatry service does not provide personal foot care, defined as toenail cutting and skin care, including the tasks that healthy adults would normally carry out as part of their everyday personal hygiene. Certain conditions are excluded e.g. Verrucae. The service does not provide annual diabetic reviews where there is no podiatric need or home visits.

Treatment will follow care pathways which will include one-off treatments and short courses of treatment leading to discharge from podiatry.

Date of referral: / /		
YOUR DETAILS		
Title: (Mr, Mrs etc.)	First name:	Middle name:
Surname:		
Sex: Male Female	Birth date: / /	
NHS Number (if known, it can be found an a prescription form if you have one) :		
Address including postcode:	Contact Telephone Number(s): Home: Mobile: We use an appointment reminder service, so we will use your mobile for automated reminders. If you do not wish to receive these, you may opt out by informing us.	
Do you have a Learning Disability: Yes / No		
Are you allergic to anything? (please state what)		
Who is your registered GP?		
Which practice are you registered with? (include address)		
WHY ARE YOU REQUESTING A PODIATRY APPOINTMENT?		
Please describe your foot problem and how you have tried to improve it already.		
Has a referral been made to Podiatry in the previous six months? (referrals are not accepted for the same condition within six months)		

Please tell us about your Medical History
(Especially relevant; Diabetes, Rheumatoid arthritis, Heart disease)
What medication do you take? (Tablets, injections, creams etc.)

Please complete before forwarding.			
Signature (unless completing the form electronically)	Name (print)	Relationship to person requesting appointment	Today's date

To help us ensure that the service we provide is equally accessible to everyone, we are required to record the ethnicity of the people that use our service. This information will be treated with confidentiality. Please look at the following list and tick the ethnic group to which you belong.

Ethnic Origin: (please tick one of the boxes below)

White British		**Pakistani**		**Other Asian Background**	
White Irish		**Bangladeshi**		**Other Black Background**	
White & Asian		**African**		**Other Mixed Background**	
White & Black African		**Caribbean**		**Other Ethnic Background**	
White & Black Caribbean		**Chinese**		**Indian**	
Other White Background					