Self-Request for Podiatry Assessment

This form should be emailed to: LHNT.LCHSCAB@nhs.net. It would be helpful if electronic photographs of your foot problem are attached (please use the .jpg format and ensure the photographs are less than 1.5Mb each). If you are unable to send this in electronically, please post it to: Podiatry Service, Newland Health Centre, 34 Newland, Lincoln LN1 1XP.

When the completed form is received, a senior 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. Incomplete forms will be returned.

Exclusions
The Podiatry service does not provide personal foot care, such as toenail cutting and skin care. Certain conditions where no, or limited effective treatment is available will not be offered appointments, e.g. Verrucae, asymptomatic flat feet, Bunions and clawed toes, Heel pain in adults. For certain conditions telephone consultations and advice will be offered. The service does not provide annual diabetic reviews or home visits.

Nail Surgery
The Podiatry Service can only consider requests for nail surgery for patients who are over eight years old and under 16 and who are suitable for nail surgery in a community setting. Adult surgery for ingrowing toenails is provided through the primary care surgical scheme (PCSS). Please contact your GP to arrange direct referral to your preferred provider of this service.

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

PATIENT INFORMATION		
Title:	First name:	Middle name:
Surname:		
Sex: Male Female	Birth date: / /	
First Language:	Translator Required:	Yes/No
NHS Number:		
House No. / Name:	Contact Telephone No:	
Address:		
Town:	County:	Postcode:
Smoker: Yes / No	Learning Disability: Yes / No	
Known allergies (if any):		
REFERRING INFORMATION:		
Name of referrer:	Professional group: GP/Nurse/etc.	
Patients Registered GP (If different from above)		
Address:		Telephone:
Town:	Postcode:	

Please complete both sides of this form

REASON FOR REFERRAL:
Description of condition /duration / location – please give as much information as possible (include treatments tried to date):
Is this referral URGENT eg. Foot Ulceration?
Have you been seen a Podiatrist in the previous six months? (referrals are not accepted for the same condition within six months)
MEDICAL HISTORY:
(Especially relevant; Diabetes, Rheumatoid arthritis, Heart disease, Neuropathy, Peripheral Ischaemia)
Current medication: Please list all currently prescribed medication.
The contents of this form and any included photographs form part of your request for assessment. They will be used within our triage process and will be attached to your medical records. By completing this form you agree to this process.

Name of person completing form (block capitals)	Signature (not required if submitted electronically)	Relationship to patient (if form completed by someone else)	Today's date: