

Podiatry Referral Form

Patient Details NHS No _____
 Surname _____ Mr Mrs Ms
 First Name _____
 Address _____
 _____ Postcode _____
 Tel _____ DOB _____

GP Practice Stamp

Please note that a referral should only be made when there is an identified clinical foot health need

Toe nail cutting is only available for abnormal nails and where a medical reason is indicated i.e. diabetes and only where this is deemed high risk

Newly diagnosed diabetics should only be referred where a risk factor has been identified

Section A - Foot problems

Skin	Normal	Fungal/verrucae	Corn/callus	Sepsis	Foot ulceration
Nails	Normal	Fungal	Thickened	Curved	Ingrowing
Pain	None	Slight	Moderate	Severe	Extreme
Deformity	None	Mild	Moderate	Severe	Extreme

Musculo-skeletal	Morton's neuroma	Pes Planus / Plantar Fasciitis	Achilles / Ankle pain	Knee related foot pain	Other MSK related foot pain
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Section B - General Medical

None	COPD	Neurological
Neuropathy	Mental Health illness	Rheumatoid arthritis
CVA	Nephropathy	Diabetes
Physical Disability	Osteoarthritis	Amputee
Registered blind	Immunosuppression	Lower limb ischemia

Please circle all relevant responses

Other reason for referral _____
 Related History including any infection conditions e.g. MRSA _____

Please list any current medication or attach copy of prescription list

Name/Designation of referrer _____ Name of GP _____
 Interpreter required / Language _____ Date _____

To prevent delays in patient care all sections of this form must be completed and returned to : Podiatry Department, One Life, Linthorpe Road, Middlesbrough TS1 3QY or email to: podiatry.clinic@nhs.net