Bristol Community Health

NHS

Podiatry Clinic Referral Form V6 July 2014

Please return your completed form to: **Podiatry Department, Knowle Clinic, Broadfield Road, Knowle, BS4 2UH Tel: 0117 919 0275 Fax: 0117 9 190 259**

Please complete all the sections of this form. If we require more information to process your application we may return this form to you. Please make sure that you provide a day time contact telephone number.

WE DO NOT PROVIDE A TOE NAIL CUTTING SERVICE.
All treatment will be based on medical & podiatric need.

PATIENT DETAILS	
Title: Title **Forename:** Given Name **Surname:** Surname	**D.O.B:** Date of Birth **Male/Female:** Gender **Home Tel Number:** Patient Home Telephone
Address: Home Full Address (stacked)	**Work Tel Number:** Patient Work Telephone **Mobile Tel Number:** Patient Mobile Telephone **If you do not wish to receive a text reminder of your appointment please tick this box:** ☐ **E-mail:** Patient E-mail Address
NHS Number: NHS Number	**Interpreter Required Yes** ☐ **No** ☐ **Language Spoken:** Main Language

NEXT OF KIN	**GP DETAILS**
Title: **Forename:** **Surname:**	**Doctor:** Dr Usual GP Forenames Usual GP Surname

Address: **Relationship:** **Telephone Number:**	**Practice Address:** Whiteladies Health Centre Whatley Road Clifton Bristol BS8 2PU **Telephone Number:** 0117 9731201

PLEASE TURN OVER TO COMPLETE REVERSE OF FORM

Patients Name: Title Given Name Surname NHS: NHS Number

Do you have an open wound on your foot? **YES** ☐ **/ NO** ☐

If **YES** please give details:

If **NO** Please tell us as much about your thoughts on your foot problem as you can:

My main foot or nail problem is:

Medical History - Please list or attach print out from GP Surgery:

Allergies:

Medication - Please attach a prescription or provide a list of all medications (include any that you may self prescribe):

Additional Information: Please complete as much as possible:

Diabetes	Yes ☐ / No ☐	*Last HBA1c:*	
Last foot screen result	Low ☐ / Increased ☐ / High ☐ / Ulcerated ☐		
Neuropathy	Yes ☐ / No ☐	Peripheral arterial disease	Yes ☐ / No ☐
Is the patient receiving treatment at any hospital? – please provide details	Yes ☐ / No ☐		

Completed by: ☐ Podiatrist ☐ GP ☐ Nurse ☐ AHP ☐ Guardian ☐ Self

Signed _____ **Contact Tel no**: _____ **Dated** _____

Name Printed _____

Office Use only:

Date received _____ Triaged by & Date _____

Priority status: ☐ Urgent ☐ Routine ☐ Diabetic