Podiatry (Foot Health)
Services Self Referral Form

NHS Ayrshire & Arran

Please complete ALL sections of this form by filling in the boxes and answering all of the questions.

Full completion of this form allows us to identify your foot health needs, enabling us to direct you to the right part of the Podiatry Service. If the form is not fully completed, the result could be a delay in the issue of your appointment.

If you require this form in another language or format please contact

NHS Ayrshire and Arran – ☎ Tel: 0800 169 1441

Personal Information			
Name:		**Date of birth:**	
Address and postcode:		**Is this address a care/residential home?** ☐ **Yes** ☐ **No** **If yes, please provide previous address:**	
Tel No:		**Mobile No:**	
GP Information			
GP:		**GP Tel No:**	
Practice:			
Emergency Contact or Care Support Information			
Name:		**Tel No:**	
Address:			
Relationship:			

Appointment Support	Yes	No
Due to availability of specialist equipment, do you weigh more than 25 stones/159kgs		
Do you require wheelchair access?		
Do you require communication support? If YES, please tick the appropriate box below: British sign language interpreter ☐ Lip speaker support ☐ Deaf blind communicator support ☐ Community language interpreter ☐ Large print appointment information ☐ Other (please specify) _____		

Reason for referral - complete relevant boxes below		YES	NO
1	A skin complaint?		
2	A nail complaint?		
3	A foot deformity?		
4	Muscle or joint pain in the foot		
5	Muscle or joint pain in the ankle/knee/hip/back?		
6	Do you currently have a foot wound (which is not a corn or callus)?		
7	Are you currently taking antibiotics for the foot condition you are contacting the Podiatry Service about? If the answer is YES, for how long? . . . . . weeks		

Reason for referral - complete relevant boxes below		YES	NO
8	Is your foot condition RED?		
9	Is your foot condition SWOLLEN?		
10	Is your foot condition DISCHARGING or WEEPING?		
11	How long have you had this condition? Less than 2 weeks ☐ Between 2-12 weeks ☐ Over 12 weeks ☐		
12	Does your foot condition affect your ability to walk (ie make you limp) or carry out your daily tasks?		
13	Is the condition you are contacting the service about the result of a recent accident or injury? Date of accident / injury		
14	Have you had a previous fracture of your lower limb? If YES, please state which part: Foot ☐ Ankle ☐ Lower Leg ☐ Hip ☐ Thigh ☐ Knee ☐		
15	Does this foot condition cause you any pain? If you have answered YES please use an X to indicate your pain level on the pain scale below. 0 — 10 No pain — Severe pain		
16	Does this foot condition affect your ability to attend your current occupation / school? Please state occupation		
17	Are you self employed or work for a small company (fewer then 250 people)?		
	Medical Information and Medication	YES	NO
18	Do you have DIABETES? If YES, please tick the box that represents your foot risk category. Low Risk ☐ Moderate Risk ☐ High Risk ☐ Active Foot Disease ☐ Unknown ☐		
19	Have you had a stroke?		
20	Do you have any circulation disorders? Raynaulds disease ☐ Varicose veins ☐ Vascular disease ☐ Vasculitis ☐ Vascular Dementia ☐ Lymphodema ☐		
21	Do you have any neurological disorders? Multiple Sclerosis ☐ Muscular Dystrophy ☐ Motor Neurone Disease ☐ Parkinson's Disease ☐ If none of the above, please specify:		

Medical Information and Medication continued		YES	NO
22	Do you have kidney disease? If YES, are you on renal dialysis? YES ☐ No ☐		
23	Do you have any other type of arthritis e.g. rheumatoid arthritis, psoriatic arthritis? If YES, please specify:		
24	Have you had a joint replacement or other implant? If YES, please specify:		
25	Do you have any of the following? HIV ☐ Hepatitis ☐ Creutzfeld Jakob disease ☐		
26	Do you have any mental health conditions e.g. depression, anxiety? If YES, please specify:		
27	Do you have any learning disabilities?		
28	Are you pregnant? If Yes, please state how many weeks		
29	Are you registered blind or partially sighted?		
30	Do you use a walking aid e.g. walking stick, leg brace, zimmer frame?		
31	Do you have a carer to help with your daily needs?		
32	Do you carry a medical warning card? If YES, please specify:		
33	Do you have any allergies? If YES, please specify:		
34	Do you have any other medical conditions? If YES, please specify:		
35	Do you take any prescribed medication? If YES, please specify (you can also attach a list of your medication to this form)		

Other Information		Yes	No
36	Have you attended the Podiatry Service before? If YES please state when:		
37	Is there any other information you wish to add?		

Signed		Date	
	Patient / Carer / Parent / Guardian / Health Professional If used by a Health Professional, please state profession and contact number:		

Please return all completed forms to:

Podiatry Service,
Arrol Park Resource Centre,
Doonfoot Road,
Ayr
KA7 4DW

For Office use Only

CHI Number: . . . . . .

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Short term int	HR	DAR	MSK	EN

CL	Dom	Care Home

Admin: Has patient been previously registered with Podiatry? If yes, give details:

Date Location

Any additional triage notes:

Triaging Clinician's Name: . . . . . Date: . . . . . .