Office Only
Date Received……
TIARA No: ……..
Triaged: Routine / Urgent
Clinic: ……..
Appointment date: ……

Leicestershire Partnership NHS
NHS Trust

Community Health Services
Please Return To:
Podiatry Service Call Centre
South Wigston Health Centre
80 Blaby Road, South Wigston
Leicester, LE18 4SE
Tel: 0116 2255118
Fax : 0116 2255122

APPLICATION FOR PODIATRY ASSESSMENT

BOTH FORMS AND ALL DETAILS **MUST** BE COMPLETED SO WE CAN PRIORITISE FOR URGENCY
(Incomplete applications *will* be returned)

Please note – the Podiatry Service does NOT provide routine nail cutting unless you are classed as medically high risk e.g. High Risk Diabetic or severe circulation problems
Home Visits are only available if you are completely Bed or Housebound from medical conditions

NHS NO		**TITLE** (tick)	MR	MRS	MISS	
SURNAME		**FORENAME**				
Date of Birth		**FAMILY GP NAME & ADDRESS**	Kingsway Surgery 23 Kingsway Leicester LE3 2JN			
FULL ADDRESS		**NEXT OF KIN/ CARER CONTACT**	Name:			
POSTCODE			Telephone:			
TELEPHONE	***IMPORTANT– we will ring you to book an appointment. If you do not have a telephone, please indicate N/A – an appointment will be sent in the post.***					
☎ **Home:**		**Consent to leave answer phone messages** Yes ☐ No ☐				
☎ **Work:**		**Consent to contact at work** Yes ☐ No ☐				
Provide your mobile number and you will receive text message reminders of your appointments						
☎ **Mobile:**	07899742090	**I do not wish to receive text reminders** ☐ (consent assumed otherwise)				
Email Address:						
	(by supplying your email; we will assume we have consent to contact you in this way)					

Do you have any special requirements / needs when being contacted, assessed or treated by Podiatry Services?

Need an Interpreter		Please state language			
Need a Chaperone		Suffer with deafness		Use a Wheelchair	
Other needs		*Please state			

Referrer

Patient		Carer		Consultant		District Nurse		Practice Nurse		**INCH**	
GP		AHP		DSN		Other		AQP ref		LOROS	

*Please state Name of referrer if other than the patient and relationship if carer

PODIATRY NEED

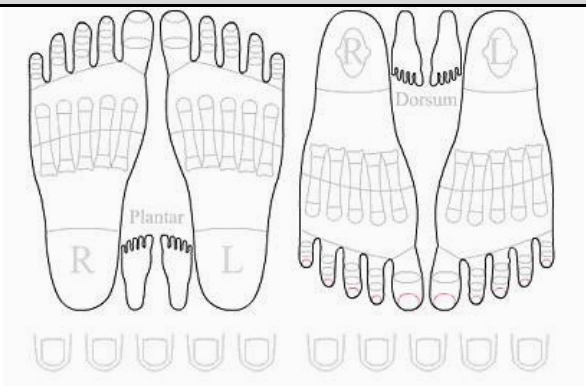
Please give detailed explanations of the current problem(s) you are having

Please note – the Podiatry Service does NOT provide routine nail cutting

Home Visits are only available if you are completely Bed or Housebound

Are you having problems with your:												
Right Foot		Left Foot		Both Feet		Toe Nails		Legs		Back		
IF Nails, are they		Ingrowing		Thickened		Distorted		Curly				

Please explain what the problem is and indicate on the diagram below where, if on the feet or to do with the nails:



Sole of Foot **Top of Foot**

Are you in pain?	**Yes**		**No**		**If yes from 1 to 10 how bad is the pain?**	

Please describe the pain and when it occurs e.g. when wearing certain shoes or running

Have you got an open wound?	**Yes**		**No**		
Do you think you have an infection (not fungal)?	**Yes**		**No**		

If yes, please see your GP as soon as possible as you may need antibiotics.

Is your problem affecting your mobility?	**Yes**		**No**		

If Yes please explain how

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

White British		**Indian**		**Other Asian Background**	
White Irish		**Pakistani**		**Other Black Background**	
White & Asian		**Bangladeshi**		**Other Mixed Background**	
White & Black African		**African**		**Other Ethnic Background**	
White & Black Caribbean		**Caribbean**			
Other White Background		**Chinese**		**Prefer not to State**	

Signature:		**Date**:	
Print Name (if you are not the patient):			

PLEASE NOW COMPLETE THE ATTACHED MEDICAL HISTORY FORM AND RETURN BOTH
Your application cannot be processed without BOTH forms

Leicestershire Partnership NHS
NHS Trust

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PODIATRY SERVICE MEDICAL HISTORY QUESTIONNAIRE

BOTH FORMS AND ALL DETAILS **MUST** BE COMPLETED SO WE CAN PRIORITISE FOR URGENCY
(Incomplete applications *will* be returned)

NHS NO		**TITLE** (tick)	MR	MRS	MISS	
SURNAME		**FORENAME**				

Please answer all the questions. If you answer YES please give more detail, if you answer NO please move to next question

Do you have Diabetes?	YES		NO		Don't Know						
If Yes – what Type	Type I		Type II		Other*						
*Please State:											
How long have you been diabetic?		Years	Recently Diagnosed								
How do you control your diabetes?	Insulin		Tablets		Both		Diet				
What was your last HBA_1C test result?			When was this taken?								
Do you have heart trouble?	YES		NO		**If NO please move on to next question**						
Heart attack		Angina		Heart Failure		CHD		*Other			
*Please State											
Do you have chest trouble?	YES		NO		**If NO please move on to next question**						
COPD		Asthma		*Other							
*Please State											
Do you have circulation trouble?	YES		NO		**If NO please move on to next question**						
Peripheral Vascular Disease (PVD)		History of Deep Vein Thrombosis (DVT)		Stroke							
Raynaud's disease		History of Chilblains		*Other							
*Please State											
Do you have bone or joint trouble?		YES		NO	**If NO please move on to next question**						
Rheumatoid Arthritis		Osteo Arthritis		Inflammatory Arthritis e.g. Psoriatic							
Had any broken bones or fractures to legs or feet (please state below)		*Other									
*Please State											
Do you have Neurological problems?		YES		NO	**If NO please move on to next question**						
Neuropathy		Paralysis		*Other							
*Please State											
Do you have any Skin Conditions?		YES		NO	**If NO please move on to next question**						
Eczema		Psoriasis		*Other							
*Please State											
Do you have Mental Health Problems?		YES		NO	**If NO please move on to next question**						
Dementia		Alzheimer's		*Other							
*Please State											
Do you have any Allergies?		YES		NO	**If NO please move on to next question**						
Antibiotics (Please state which ones below)		Plasters		Latex / rubber		*Other					
*Please State											

Please Turn Over

Are you taking any of the following medication?				
Drugs to thin your blood e.g. Warfarin or Aspirin*		YES		NO
*If YES what are you taking?				

Version 1:November 2016

Beta Blockers e.g. Bisoprolol		Statins e.g. Simvastatin		GTN		Inhalers			
Any other type of medication*		YES		NO					
*If YES then please list:									
Have you had any Operations to the following areas? (Please tick all that apply)									
Foot or Feet		Ankle(s)		Leg(s)		Hip(s)		Back	
If you have ticked any of the above, please describe what you have had done, which foot / leg, where and why?									
Please list any other operations you have had that you may consider relevant:									
Please provide any other information that you feel might be relevant to us with regards your application for Podiatry Assessment:									

Please Return Both Forms To:

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Lines Open Mon – Fri 9am – 4pm