


<i>For office use only</i>		 NHS Highland
Urgent /Routine/MSK/ B5	Chi.....	
Date referral received		

NHS Highland Podiatry Service DOES NOT carry out SIMPLE nail cutting

Each patient will be assessed so an individually tailored management plan can be agreed.
Treatment may not be given during this initial assessment.

Please return completed forms to:

Highland Podiatry Department, 24 Abban Street, Inverness IV3 8HH (Tel. 01463 723250)

All sections must be completed in BLOCK CAPITALS

Personal Information					
First name:		M <input type="checkbox"/> F <input type="checkbox"/>	DOB:		
Surname:			Title		
Address:		Please place 'X' in box to indicate your preferred contact	Home		<input type="checkbox"/>
			Mobile		<input type="checkbox"/>
			Work		<input type="checkbox"/>
Post Code		e-mail			<input type="checkbox"/>
GP Practice		Tel No.			

Reason for referral (you can select more than one option)		
Side:	Left <input type="checkbox"/>	Right <input type="checkbox"/> Both <input type="checkbox"/>
Region of the Foot:	Toes <input type="checkbox"/> Heel <input type="checkbox"/> Arch <input type="checkbox"/> Top of Foot <input type="checkbox"/> Sole of Foot <input type="checkbox"/> Side of Foot <input type="checkbox"/> Ankle <input type="checkbox"/>	
Other Lower Limb Regions :	Knee <input type="checkbox"/> Hip <input type="checkbox"/> Back <input type="checkbox"/>	
Structure:	Nails <input type="checkbox"/> Skin <input type="checkbox"/> Muscle/Tendon <input type="checkbox"/> Joint <input type="checkbox"/> Other <input type="checkbox"/> (specify)	
	Yes	No
Is the problem area red?	<input type="checkbox"/>	<input type="checkbox"/>
Is the problem area swollen?	<input type="checkbox"/>	<input type="checkbox"/>
Is the problem area bleeding / discharging / weeping?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking, (or have recently taken), antibiotics for this problem?	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other information you wish to add?		

Continue overleaf

How long have you had this problem?

Less than 2 wks 2-12 weeks 3-12 months Over 1 year

Have you had treatment for this problem before? Yes No

If Yes please state where and by whom.

Is the problem causing pain? Yes (use X to indicate pain level on scale below) No

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Ever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Do you have Diabetes? Yes No

If YES please tick the box that represents your foot risk category at your last foot check up.

Low Risk Moderate Risk High Risk Active Foot Disease Don't Know

I've never had my feet checked

Please list all other medical conditions

If **NONE** please tick this box

Please list all CURRENT MEDICATIONS (attach a prescription tear-off slip if possible)

If **NONE** please tick this box

Allergies? Yes specify No

Is the problem preventing you from attending work / school?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you self employed or work for a small company (fewer than 250 people)?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Appointment Support: If you require communication support please specify below

British Sign Language interpreter Language interpreter (language)

Other specify..... **None required**

Do You Attend Day Care Yes Days of week..... No

Do you have a physical disability? Yes Specify No

Emergency Contact

Name		Tel. no.	
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Print name:	Date:
Relationship if completing on behalf of patient:	

Please note incomplete forms will be returned which may result in a delay in issuing an appointment