NHS
Royal Devon University Healthcare
NHS Foundation Trust

PODIATRY REFERRAL FORM

HOW DO I APPLY?

You can self-refer to the podiatry department by completing this application form and sending it to the address below. Please include as much information as possible in order for us to prioritise your referral and book an appropriate appointment (face to face or telephone). If you need help completing the form please contact the Podiatry Office on the number below.

If possible please attach a photograph of your current foot problem.

Northern Podiatry Services	**Eastern Podiatry Services**
Barnstaple Health Centre, Vicarage Street Barnstaple EX32 7BH	Newcourt House, Newcourt Drive, Old Rydon Lane Exeter EX2 7JQ
Alternatively, you can email it to **Northern services**: rduh.podiatry@nhs.net **01271 341509** (Monday to Friday 0900 – 1600)	Alternatively, you can email it to **Eastern services**: rduh.podiatryappointments-eastern@nhs.net **0345 266 7772** (Monday to Friday 0900 – 1600)

PERSONAL DETAILS

Name: Mr/Mrs/Miss/Ms	Date of Birth: ...../..... /.....
	NHS No. (if known):
Address: Post Code:	Mobile:
	Daytime contact number:
	Email:
Please advise on your preferred contact method? (Please circle): Mobile/ Daytime contact number/ Email/ Letter	
Name of your GP, Surgery name, address and telephone number:	

REASON FOR REFERRAL (please note we do not provide simple nail cutting)

Which of the following affects you at present? Please tick all the relevant boxes and give more detail below

Foot ulcer/wound		Amputation		Corn/callus		Foot pain		
Black/dark area		Infection		Ingrowing nail		Foot deformity		

Further details:

Please indicate on the diagram below which areas are causing you pain or discomfort and level of pain:

Right Foot Top

Right Foot Sole

Left Foot Sole

Left Foot Top

Pain score (please circle) 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain, 10 = severe pain)

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MEDICAL HISTORY

For safe effective care it is important that we have a complete picture of your health, past and present.
Please tick and complete in dark ink if any of the following apply to you:

Health problem:	Yes	No	Details:
Allergies e.g. - Penicillin/ iodine			
Diabetes Mellitus At your last annual foot check, what was your diabetic foot risk? Have you previously had an amputation or charcot foot?			Type:
Severe renal/kidney disease or on dialysis			
Heart disease or respiratory disease			
Stroke/TIA (mini stroke)			
Neurological disorder			
Inflammatory Arthritis e.g. Rheumatoid			
Peripheral Vascular Disease (PVD)/ Lymphoedema			
Previous operations affecting feet or legs			
Immunosuppressant medication or current cancer therapy			
Pregnant or breast feeding			
Communication difficulties If yes, would you benefit from additional support? In what way?			
Neurodiversity i.e. autism If yes, would you benefit from additional support? In what way?			
Other relevant medical information			

MEDICATION

Please list all your current medication or attach a copy of your current prescription:

Is a translator required? Yes ☐ No ☐ Please specify:

Applicant Name: .....

Date: ..... **Signature:** .....

If you are the applicant's representative please complete below and state why it has been necessary for you to fill in the form and not the patient:

Name: .....

Date: ..... **Signature:** .....

Contact Tel: ..... **Relationship to applicant:** .....

Any other information: .....

We will contact you with an outcome of your referral.