

**PODIATRY SERVICE – APPLICATION FOR ASSESSMENT**

Please complete as fully as possible, as this information will be used to determine whether you are offered an assessment and how long you might wait.

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Forename: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_ NHS Number: \_\_\_\_\_  
 \_\_\_\_\_ Hospital Number: \_\_\_\_\_  
 \_\_\_\_\_ GP's Name: \_\_\_\_\_  
 Postcode: \_\_\_\_\_ GP's Address: \_\_\_\_\_  
 Home Tel: \_\_\_\_\_  
 Work Tel: \_\_\_\_\_

Why do you need treatment for your feet? \_\_\_\_\_

Have you ever had a foot ulcer? \_\_\_\_\_

Have you ever suffered or are you suffering from any of the following?

Please tick all that apply:

- |  |   |
|--|---|
| 1. Diabetes? <input type="checkbox"/>                | 5. Do you have a pacemaker? <input type="checkbox"/>                            |
| 2. Rheumatoid arthritis? <input type="checkbox"/>    | 6. Have you ever been diagnosed with poor circulation? <input type="checkbox"/> |
| 3. Neurological conditions? <input type="checkbox"/> | 7. Have you ever had a foot or part of it amputated? <input type="checkbox"/>   |
| 4. Heart disease? <input type="checkbox"/>           | 8. Which ethnic group do you belong to? _____                                   |

What medication (i.e. tablets and injections) are you taking? These may be from your Doctor or the chemist. (Please give names). \_\_\_\_\_

Are there any special needs or other information you think we should know about? (e.g. wheelchair). \_\_\_\_\_

Referrer's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Designation: G.P./ D.N. / Self / other please state: \_\_\_\_\_

**FOR OFFICIAL USE**

Date Referral Received: \_\_\_\_\_

Triage Date: \_\_\_\_\_  
 Insufficient info: *Letter sent:* \_\_\_\_\_  
 Assessment: Eligible  Ineligible   
 Risk Group: 1 2 3

Information on this questionnaire is protected under the Data Protection Act 1984 and will only be used by South East Essex Primary Care Trust

POD/REF APPENDIX 1

**PLEASE RETURN FORM TO: Podiatry Appointments Office, Thurrock Hospital, Long Lane, Grays, Essex. RM16 2PX – Fax No : 01375 364629**