Torbay and South Devon
NHS Foundation Trust

Department of Podiatry and Foot Health

Patient Information and Application Form for Podiatry Assessment

What is Podiatry?

Podiatry is the assessment, diagnosis and treatment of the human foot. In Torbay and South Devon the following podiatry services are available:

- Foot health education for patients and carers
- Courses of treatment for painful foot problems
- Episodes of care and review of people with at-risk feet
- Treatment of developmental foot abnormalities
- Toe nail surgery
- Wound care

Access to treatment depends on your specific foot and health problems. We are unable to provide treatment for nail cutting, footwear related corns and callus, and non-painful foot problems unless your feet are assessed at high risk or ulcerated. We limit access to ensure that people who have the highest risk receive the treatment we feel appropriate from the service. The type of conditions that could put your feet at risk are diabetic neuropathy, peripheral arterial disease, a history of ulceration or infection and rheumatoid arthritis (please note this is different to the more common osteoarthritis).

PLEASE NOTE WE DO NOT ACCEPT REFERRALS FOR PERSONAL/SIMPLE NAIL CARE.

How do I apply?

You can self-refer by completing the application form on the opposite page and sending it to us at the address below. A podiatrist will then assess your application and decide whether you need assessment or advice.

We will contact you with an assessment appointment. Your feet will be examined, medical history taken and footwear assessed so that your individual needs can be identified and a joint treatment plan agreed. Please bring an up-to-date list of medication with you.

If you need help completing the form please contact the Podiatry Office on the number below.

Where do I send my form?

Torbay and South Devon NHS Foundation Trust
St. Edmunds
Victoria Park Road
Torquay
TQ1 3QH

Need help completing this form?

Tel: 01803 217712

Opening Hours
Monday - Friday 8.45am - 3.45pm

Patient Name: NHS:

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PODIATRY REFERRAL FORM

Please complete the Part A of the form below in BLACK INK. It is essential that you COMPLETE ALL the form so that we can assess your eligibility for Podiatry treatment. All information you provide is treated confidentially.

Please send the COMPLETED form by post to the address below.
Alternatively, you can email it to: t-sd.podappts@nhs.net

Torbay and South Devon NHS Foundation Trust
St. Edmunds, Victoria Park Road,
Torquay TQ1 3QH
Telephone: 01803 217712

PART A

Name: Mr/Mrs/Miss/Ms	Date of Birth: ...../..... /.....	
Address: Post Code:	Daytime contact Telephone:	
	Mobile:	
	Occupation:	
	Email:	Ethnicity:
Name of your GP: Surgery name, address and telephone number:		
Is English your first language? **Yes/No** If no, please specify: Is an interpreter required **Yes/No**	Do you have any religious/spiritual requirements we may need to consider? **Yes/No** If yes, details please:	
Do you carry a health-warning card? **Yes/No** If yes details please:	Next of Kin/person to contact in emergency: Name: Contact Tel: Relationship:	
Is it necessary for a carer to attend appointments with you? **Yes/No** Please give details of your carer if applicable: Name: Contact Tel: Relationship to applicant:	Do you have any physical impairments/learning difficulties? E.g. partially sighted **Yes/No** If yes details please:	
Do you have any mobility problem? **Yes/No** If yes details please:	If in a wheelchair can you transfer to a hospital couch? **Yes/No**	
Do you have any mental health issues/dementia? **Yes/No** If yes, details please:	Is capacity compromised? **Yes/No** If yes does someone have lasting power of attorney for health? **Yes/No** If yes, details please:	

Patient Name:
NHS:

Torbay and South Devon
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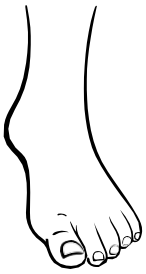
PART B						
Which of the following affects you at present? Please tick all the relevant boxes.						
Pressure Ulcer		Corn/callus		Heel pain		Other (please specify)
Ulcer/foot wound		Toe nail problem		Foot pain		
Black area		Ingrowing toe nail		Foot deformity		
Infected foot		Bunion				

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


Right Foot Top


Right Foot Sole


Left Foot Sole


Left Foot Top

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 **black ink** if any of the following apply to you:

Health problem:	Yes	No	Details:
Allergies e.g. - Penicillin/Inadine			
Diabetes – Date diagnosed?			
Endocrine disorders e.g. Under active Thyroid			
Renal disease e.g. Kidney problems			
Heart disease			
Blood pressure problems			
Respiratory disease e.g. COPD/Emphysema			
Stroke/TIA			
Neurological disorders e.g. Parkinson's/MS			
Epilepsy/fits/fainting or convulsions			
Connective tissue disorders e.g. Scleroderma/Gout or Rheumatoid Arthritis			
Osteoarthritis/Osteoporosis			
Back or spinal problems			
Diagnosed with Peripheral Vascular Disease (PAD)/ Lymphedema			
Severe skin disorders e.g. Dermatitis/Psoriasis			
Blood disorders e.g. Leukaemia/Pernicious Anaemia			
Liver problems or history of Hepatitis			
Do you have any continence problems e.g. Catheter/use continence pads			
Infectious disorders e.g. MRSA/HIV/Hepatitis or are you closely related to anyone who has had CJD			
Psychological disorders/history of mental health problems leading to self-neglect			
Alcohol/drug dependency			
Pregnant or breast feeding			

MEDICAL HISTORY CONTINUED

Long term steroid therapy			
Cancer therapy			
Do you smoke Are you an ex-smoker			How many a day: Year you gave up:
Any operations affecting feet/legs/mobility or circulation			
Health Problem:	**Yes**	**No**	**Details**
Do you see a hospital consultant/specialist			Name of consultant/department:

Height:	**Weight:**	**BMI: (if known)**

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

Form completed by: Self/Patient Representative/GP/District Nurse/Other Health Professional – if form completed by health professional please complete below:

Name:		Designation:		Contact Details:	

Please tick as appropriate all of the consent boxes below and sign below	**Yes**	**No**
The information I have provided in this form is to the best of my knowledge accurate		
I understand that the information provided is confidential. I agree that this information may be shared with health and social care professionals and service providers who can contribute to my care		
I understand that I may withdraw or restrict my consent to share information at any time by informing the clinician at my appointment and this may result in a reduction of services being available		
I understand that I may withdraw or restrict my consent to share information at any time by informing the clinician at my appointment and this may result in a reduction of services being available		
The Podiatry Department have students from the University of Plymouth on placement. I consent to **observation/treatment** under supervision by a podiatry student (please delete if consent to one element is not given)		

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:** .....

ADDITIONAL REFERRAL NOTES (for office use only) **Date Received:** .....

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Triaged By: ..... **Appointment Date:** .....