

Community Podiatry

Self Referral Form



Please return your form via email - Podiatry.NPReferrals@nhslothian.scot.nhs.uk

By Post: Podiatry Department, Slateford Medical Centre, 27 Gorgie Park Close, Edinburgh, EH14 1NQ

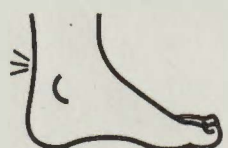
Information about you (the patient)

Name	Date of Birth
Address	Telephone Number
Post Code	Can we leave a voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No
GP Practice	Email address

WHERE is your main problem?


Please note we DO NOT provide routine treatment for fungal toenails, verrucae and toenail cutting

Ankle



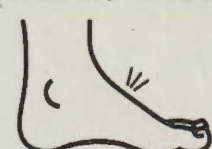
<input type="checkbox"/>	Front
<input type="checkbox"/>	Back
<input type="checkbox"/>	Inside
<input type="checkbox"/>	Outside

Heel




<input type="checkbox"/>	Back
<input type="checkbox"/>	Inside
<input type="checkbox"/>	Outside

Middle of foot



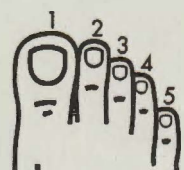
<input type="checkbox"/>	Top
<input type="checkbox"/>	Inside
<input type="checkbox"/>	Outside

Front of foot




<input type="checkbox"/>	Top
<input type="checkbox"/>	Inside
<input type="checkbox"/>	Outside

Toe



<input type="checkbox"/>	Toe 1
<input type="checkbox"/>	Toe 2
<input type="checkbox"/>	Toe 3
<input type="checkbox"/>	Toe 4
<input type="checkbox"/>	Toe 5

Bottom of foot



<input type="checkbox"/>	Toe
<input type="checkbox"/>	Ball of foot
<input type="checkbox"/>	Arch of foot
<input type="checkbox"/>	Heel

WHAT is your main problem?

<input type="checkbox"/> Pain in your muscles/joints	<input type="checkbox"/> Painful toenail
<input type="checkbox"/> A wound/ulcer	<input type="checkbox"/> Problem with your lower leg/knee
<input type="checkbox"/> Ingrown toenail with broken skin	<input type="checkbox"/> Hard Skin / Corn

Please give more detail about your problem:

Are you in pain?

How often does your problem cause you pain?

Never Occasionally Most of the time All the time

How bad is the pain when it does happen?

No Pain Mild Moderate Severe

Are you off work / studies / school because of this problem? Yes No

Your medical conditions/medication.

Are you on antibiotics for this problem? Yes No

Please list any diagnosed medical condition(s) and allergies you have.

Please list any medicines you currently take.

Do you give consent for us to check your medical records? Yes No

Your appointment. *Please note home visits are by GP referral only*

Has a podiatrist helped you for this problem before? Yes No

Are you able to attend a video appointment? Yes No

Are you happy to attend a student clinic? Yes No

If you require an interpreter what language do you require?

Please let us know if you require support for your appointment – e.g. wheelchair accessible venue, hearing loop or venue with bariatric equipment (if you are over 25 stone)

If you have completed this form on behalf of someone else because they do not have capacity to consent to treatment please provide your name, address and relation to the patient.