PODIATRY SERVICE

APPLICATION FORM FOR COMMUNITY PODIATRY ASSESSMENT

Referral Guidelines - Please read before filling in the form
Please complete all sections on both sides of this application form.
Priority will be given to applicants based on the risk and impact of their condition.
Incomplete applications cannot be prioritised and will be returned to the referrer; this may result in a delay to assessment.

PATIENT DETAILS

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Gender</th>
<th>M / F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Address inc postcode

Dob

GP

Age

Address

Tel. No

Mobile no.

Email address

Next of kin / Emergency contact no.

Relationship

Carer details

Do you consent to receiving a text message to remind you of your podiatry appointment date and time? Yes / No

We are asking for the following information so that we can ensure we are providing the best health care services to all our patients. The information is kept confidential and will only be used for statistical purposes.

Please indicate your ethnicity from the options below:

- Asian or Asian British: Bangladeshi, Indian, Pakistani, Any other Asian background
- Black or Black British: Caribbean, African, Any other Black background
- White: British, Irish
- Dual Heritage: Asian & White, Black & African, Black Caribbean & White, Chinese & White, Any other dual heritage background

Chinese or Chinese British

Any other ethnicity (please describe)

Not stated

Do you require an interpreter? Y | N Which language?

How do you describe your religion or belief? Please tick one of the following:

- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Sikh
- None
- Do not wish to disclose
- Other (please describe)

Do you consider yourself to be disabled? Yes / No

Are you able to attend a clinic for your assessment Yes / No

If No please give a reason:

Do you go out for other reasons Yes / No

If yes how do you travel?

Do you receive mobility allowance? Yes / No

Please Note: If you require a home visit for a podiatry assessment this form needs to be countersigned by your GP or other health professional overleaf.
# PODIATRY SERVICE

**NAME OF APPLICANT**

Please list all medical conditions / physical disabilities e.g. diabetes, rheumatoid arthritis, peripheral vascular disease, peripheral neuropathy. If none please state none in box below

<table>
<thead>
<tr>
<th>Do you have a foot ulcer?</th>
<th>Yes / No</th>
<th>Is this a new wound?</th>
<th>Yes / No</th>
</tr>
</thead>
</table>

If yes, please describe where

Please list all your current medications or attach a copy of your prescription list. If none please state none in box below

Please explain what problems you are having with your feet:

**Person who completed this form please use block capitals**

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation eg self GP DN PN. If other please specify eg relationship</th>
<th>Signature</th>
<th>Contact telephone number of referrer</th>
<th>Date</th>
</tr>
</thead>
</table>

Bootle Health Centre Park Street, Bootle, L20 3RF 0151 247 6000
Sefton Road clinic Sefton Road Liverpool L21 9HE 0151 247 6929
Maghull Health Centre Westway, Maghull, L31 0DJ 0151 247 6800
Netherton Health CentreMarion Square, Netherton, L30 5SP 0151 247 6080
Prince Street Clinic Prince Street, Waterloo, L22 5PB 0151 247 6900
Thornton Health Centre Bretlands Road, Thornton, L23 1TQ 0151 247 6330