

Criteria for referral for Podiatry treatment

Do you meet the criteria for receiving Podiatry treatment?

1	2	3
Podiatric need	Medical need	Low / No medical or podiatric risk
Foot pain (Musculoskeletal conditions) Ulceration/ non healing wounds. Infection In growing toenail with discharge Painful corns Painful callus	Neuropathic and Ischaemic limb conditions, Scleroderma, Rheumatoid or related inflammatory arthropathies, Diabetes Poor Tissue Viability Neurological Disorders Chemotherapy, Immunosuppressive, warfarin (unstable INR)	General nail care Non painful callus Non painful corns Non painful verruca's

If you meet any of the criteria above in **category 1 or 2** you will be offered a primary assessment appointment which may involve advice and discharge to self-care or an intense block of treatment to meet your foot health needs.

If you fall into **category 3** you have not met the required criteria for receiving podiatry NHS treatment.

All appointments will be allocated on; the risk, patient needs and requirements.

Waiting times for appointments may vary depending on the treatment required.

If you feel you have met the criteria to receive NHS podiatry treatment please continue to complete the podiatry referral form.

N.B. The completion of this application form does not guarantee a podiatry assessment.

Patients that do not meet the criteria for access to NHS podiatry services can view our website (<http://www.rdash.nhs.uk/services/our-services/adult-doncaster-community-integrated-services/podiatry/>) for self-help information leaflets which are also available at Cantley Health Centre on how to safely manage your own foot care. Alternatively you could seek the services of a **HCPC** Private podiatrist- look in the Yellow Pages, Thompson Local or on the internet.

PODIATRY REFERRAL FORM (page 1 of 2)

THIS FORM IS TO BE USED FOR ALL NEW PATIENTS FOR COMMUNITY PODIATRY SERVICE INCLUDING NAIL SURGERY (NB This form cannot be used for referral to Podiatric surgery, Doncaster and Bassetlaw NHS Foundation Trust- They accept GP referral letter only)

FAILURE TO COMPLETE ALL SECTIONS WILL RESULT IN YOUR APPLICATION FORM BEING RETURNED AND THEREFORE DELAY YOUR TREATMENT

Have you had previous treatment from this service? YES / NO

Where.....How long ago?.....

Name: Mr/ Mrs /Miss /Dr/ Rev..... DOB:.....

NHS No Sex: Male / Female

Address:

..... Postcode:

Telephone Landline: Mobile.....

Would you like to receive updates about your appointments via SMS text messaging? YES NO

GP and Surgery Address:

Medication (Attach prescription list):

Medical History:

.....
Please tick appropriate boxes

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Amputation – toes / part of foot / lower limb
When?..... Why?..... |
| <input type="checkbox"/> Poor circulation to lower limbs | <input type="checkbox"/> Foot ulcer (are nursing team involved? YES/NO) |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Loss of feeling |
| <input type="checkbox"/> Severe breathing difficulties | <input type="checkbox"/> Other please state: |

Who currently provides your foot care? Please tick appropriate

- Self Relative Carer Private Podiatrist Other please state.....

Please state below what problems are you having with your feet? (If not completed your application will be rejected).....

.....
State below how this impacts on your day to day activities

Please indicate the current level of pain from your feet (1=none, 10= extreme)

1 2 3 4 5 6 7 8 9 10

Podiatry Services will assess your foot health need and will design the most appropriate care package.

PLEASE COMPLETE OVERLEAF

PODIATRY REFERRAL FORM (page 2 of 2)

MOBILITY ASSESSMENT

Are you fully mobile? **YES** (go to signature box below) **NO** (continue below)

Do you require a ground floor appointment due to mobility issues i.e. wheelchairs or unable to use the stairs unaided.

A very limited service is available to patients who are totally housebound*. A mobility assessment will be undertaken. We may contact your General Practitioner for further information.

I require a home visit assessment because (please tick all that apply):-

I am bedbound and have a key safe

I use a hoist and am unable to travel in a wheelchair taxi

Other State reason.....

*** Definition of housebound**

Patients eligible for a home visit by the podiatry service are those who are one or more of the following:

- Persons who are bedbound 24/7
- Persons who require hoisting in order to be moved or to travel and would become ill if travelled to local clinic.
- Persons deemed on a temporary basis to be clinically too ill to be reasonably expected to travel.

If you feel you meet the above criteria for a home visit, please tick this box for a mobility assessment form to be sent out to you (Housebound* patients only)

SIGNATURE.....DATE.....

PERSON COMPLETING THE FORM (please delete as appropriate)

SELF / RELATIVE / CARER / OTHER HEALTH PROFESSIONAL / GENERAL

PRACTITIONER / OTHER please state.....

**Please return completed forms to: -
Podiatry Services, Cantley Health Centre, Middleham Road, Goodison
Boulevard, Doncaster DN4 6ED Tel: 01302 379550 Fax: 01302 379515**

Email: PodiatryReferrals@rdash.nhs.uk