**Podiatry Non Diabetes Referral and Application Form**

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| --- | --- | --- | --- | --- |
| **Category 1** | **Category 2** | | **Category 3** | **Category 4** |
| **Foot Wounds and Infections** | **Medical need** | | **Foot Pain Musculoskeletal foot problems** | **Non-eligible conditions** |
| -Non-healing foot wounds (ulceration)  -Foot infection which has required antibiotic treatment (excluding fungal nails)  -Ingrowing toenail with inflammation/ infection  **All diabetes foot ulcer in people who are mobile – Do not complete this form.**  **Please refer to**  [Acute Diabetic Feet (Adults) (leedsth.nhs.uk)](https://nww.lhp.leedsth.nhs.uk/leedspathways/detail.asp?id=86) | Diabetes  \*Moderate risk classification  \*High risk classification  For moderate and high risk complete DART form and send via Diabetes SPA.  If someone is bed bound and there is a diabetes foot problem, complete  DART form and send via Diabetes SPA | - Neuropathy (loss of feeling in the lower limb due to a medical condition)  - Peripheral arterial disease (very poor circulation in the lower limb)  - Rheumatoid / inflammatory arthritis  - Neurological disorders (affecting mobility or sensation)  - History of foot ulcers  - Undergoing chemotherapy  - Kidney dialysis  - Non-traumatic foot/leg amputation | **Adults**  - Foot pain from musculoskeletal foot conditions such as plantar fasciitis (heel pain), severe foot deformities (hammertoes/ bunions) that may require surgery.  -Pressure management:  i) Painful corns  ii) Painful, large area of callus  **Children** – foot pain in isolation, changes to feet or difficulties with feet. | \*General nail care  \*Minimal or non-painful callus and or corns  \*Verruca  \*Diabetes  (low risk foot classification) |

If you meet any of the criteria above in category 1, 2 or 3 you will be offered a primary assessment appointment, which may involve advice and discharged to self-care or a short block of treatment to manage your foot health needs. If your condition is within category 4, NHS podiatry treatment will not be provided.

All appointments will be allocated on; the medical risk of a serious foot problem (such as wounds), foot pain and foot disability. Waiting time for appointments may vary depending on the treatment required. If you feel you have met the criteria to receive an NHS podiatry treatment, please continue to complete the podiatry referral form.

Please note, 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:

<https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/podiatry> for self-help information leaflets on how to safely manage your own foot care. These are also available on request from our head office.

Alternatively, you could seek the services of an HCPC registered podiatrist – can be found at www.hcpc-org.uk.

|  |  |  |
| --- | --- | --- |
| **Please complete all sections.** | Name and contact details for Next of Kin: | |
| Surname: |
| Forenames: |
| NHS Number: |
| Date of Birth: | GP Name | |
| Address: |  | |
| Telephone (Home): |
| Telephone (Mobile): | Would you like to receive updates about your appointment by Text message (SMS) | |
| Email: | Yes | No |

**Main language spoken: English   
Interpreter required?** YES / NO

**Previous treatment from this service?** YES / NO

|  |  |
| --- | --- |
| **Where? …………………………………………** | **How long ago?.....................................................** |

**Please state the foot problem(s)** (please ensure this is completed, if not the application will be returned for further information):

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  
**Attach photograph of pathology.** YES / NO

**Please state below the impact on day to day activities / wellbeing:**

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  
**Please indicate the current level of pain in the feet** (0= None / 10= Extreme)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Medical history: (Please tick appropriate boxes)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Diabetes – low /moderate / high risk |  | Amputation - toes/part of foot/lower limb  When?.......................Why?................................. |
|  | Peripheral vascular disease |  | Active non diabetes foot ulcer |
|  | Rheumatoid/inflammatory arthritis |  | Loss of feeling |
|  | On dialysis |  |  |

**Other please state:**

…………………………………………………………………………………………………………………………………………..

**Medication (attach prescription list)**:…………………………………………………………………..............  
**Is foot care currently provided and by whom?**:……………………………………………………………………..

**MOBILITY ASSESSMENT**

Do you require a ground floor appointment due to mobility issues i.e. wheelchairs or unable to use the stairs unaided? **YES /  NO**

**A very limited service is available to patients who are totally housebound. Patients eligible for a home visit by the podiatry service are those who are one or more of the following:**

**• Persons who are completely bedbound**

**• Persons who require hoisting in order to be moved or to travel and would become ill if required to travel to a clinic**

**• Persons deemed on a temporary basis to be clinically too ill to be reasonably expected to travel**

**We may contact your GP for further information regarding this.**

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

**☐I am bedbound and have a key safe the code is ……………………………..**

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

**Please indicate your preference in the box below:**

I agree to my health records being shared with other services involved in my medical care

I do not agree to my health records being shared

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer / Applicant Name** |  | **Referrers Designation** |  |
| **Signature** |  | **Date** |  |

**Primary care referrals need to be sent via DART using the Podiatry Non-Diabetes ERAS**

**Non primary care referrers including patient self-referrals e-mail the following:**  [leedscommunitypodiatry@nhs.net](mailto:%20leedscommunitypodiatry@nhs.net).   
**If you need help completing and e-mailing the form please call podaitry Tel: 0113 843 0730.**