**Podiatry Referral and Application Form**

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| --- | --- | --- | --- | --- |
| **Foot Wounds** | **Nail Infection** | **Foot Protection Service**  **Prevention of wounds /amputation** | | **Foot Pain**  **Musculoskeletal foot problems** |
| -Non-healing foot wounds (ulceration)  -Foot infection which has required antibiotic treatment  **All people with diabetes related foot ulcer and who are mobile**  **Do not complete this form.**  **Please refer directly to diabetes MDT via**  [Acute Diabetic Feet (Adults) (leedsth.nhs.uk)](https://nww.lhp.leedsth.nhs.uk/leedspathways/detail.asp?id=86) | -Ingrowing toenail  With Infection  -Ingrowing toenail  With no infection  - Painful fungal infection requiring surgery | **Diabetes**  \*Moderate risk with foot problems complete this referral form  **All other diabetes referrals**  \*High risk classification  \*Bed bound with foot ulcer  please complete foot section on integrated diabetes referral form and send via Diabetes SPA. | **Non Diabetes**  - History of foot ulcers  - Non traumatic foot/leg amputation  2 Risk factors  - Neuropathy (loss of feeling in the lower limb due to a medical condition)  PLUS  - Peripheral arterial disease (very poor circulation in the lower limb)  OR  1 risk factor and  - Undergoing chemotherapy  - Kidney dialysis | **Adults**  - **Forefoot or Heel pain**  (painful callus, neuroma, forefoot joints, plantar fasciitis)  **General foot pain**  (needing pressure management)  **Complex foot pain**  (requires advanced assessment, urgent surgical/imaging, foreign body)  **Children** – foot pain in isolation, changes to feet or difficulties with feet. |
| **Non-eligible conditions**  **We are not able to provide care.** | \*General nail care  \*Minimal or non-painful callus and or corns  \*Verruca  \*Diabetes (low risk foot classification and moderate risk if no foot problems)  Leg and foot oedema pain. Systemic neurological foot pain | | | |

If you meet any of the criteria you will be offered an assessment appointment for advice and self-care, or a short block of treatment to manage your foot pain. Waiting time for appointments may vary depending on the treatment required.

**Main language spoken:**

**Interpreter required?** YES / NO If **Yes state the language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional Needs: EG learning disability, spelling, reading, listening, or adaption sensory needs etc**

**…………………………………………………………………………………………………………………………………………….**

|  |  |  |
| --- | --- | --- |
| **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 |

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

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**Attach photograph of foot problem.** YES / NO(if none attached, referral might be returned)

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | Diabetes |  | Amputation - toes/part of foot/lower limb |
|  | Peripheral vascular disease |  | Active foot ulcer |
|  | On dialysis |  | Loss of feeling |

**Other please state:**

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

**Medication (attach prescription list)**…………………………………………………………………..................  
…………………………………………………………………………………………………………………………………………….

**Foot pain: If you have heel pain, bunion pain or big toe pain,** please complete the self-management table below (otherwise your referral will be returned). Self-management needs to be followed for a minimum of 3 months before referring into us.

**Self-Management been tried for Foot Pain?**  YES or NO

|  |  |
| --- | --- |
| **If yes, please complete**  **Type of first line intervention** | **Yes/No** |
| Change of footwear |  |
| Pain control tablets or gel |  |
| Insoles, arch supports. |  |
| Bunion pads, heel pads |  |
| Exercises |  |
| Ice/heat therapy |  |

**If no, please go to our website for self-management advice:**

**https://leedscommunityhealthcare.nhs.uk/our-services-a-z/podiatry/service-information/**

If you are unable to access the website or follow self-management advice, please ensure you let us know what support is needed to support direct contact, such as language needs, additional adjustments and accessibility.

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**Some patients may be offered a telephone consultation to further assess their needs. Please indicate if your referral is for any of the following**

**A bony foot problem that may require surgery (EG bunion or ganglion)**

**Replacement insoles/toe supports**

**A child with flat foot who is tripping/falling or has leg pain with activity**

**Are you currently off work and have a fit note because of your foot pain** YES/NO

**Are you a manual worker/work most of your job on your feet** YES/NO

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

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**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 |

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**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 podiatry Tel: 0113 843 0730.**