**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 ulcerplease complete foot section on integrated diabetes referral form and send via Diabetes SPA. | **Non Diabetes** - History of foot ulcers- Non traumatic foot/leg amputation2 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 |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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.

**If you need help completing and e-mailing the form, please call podiatry Tel: 0113 843 0730.**