




Podiatry Service Call Centre
South Wigston Health Centre
80 Blaby Road, South Wigston
Leicester, LE18 4SE
Tel: 0116 2255118
Fax : 0116 2255122

Office Only	
Date Received.....	
TIARA No:	
Triaged: Routine / Urgent	
Clinic:	
Appointment date:	

APPLICATION FOR PODIATRY ASSESSMENT

BOTH FORMS AND ALL DETAILS **MUST** BE COMPLETED SO WE CAN PRIORITISE FOR URGENCY
 (Incomplete applications will be returned)

Please note – the Podiatry Service does NOT provide routine nail cutting unless you are classed as medically high risk e.g. High Risk Diabetic or severe circulation problems
Home Visits are only available if you are completely Bed or Housebound from medical conditions

NHS NO		TITLE (tick)	MR	MRS	MISS	
SURNAME		FORENAME				
Date of Birth		FAMILY GP NAME & ADDRESS				
FULL ADDRESS						
POSTCODE		NEXT OF KIN/ CARER CONTACT	Name:			
			Telephone:			
TELEPHONE	<i>IMPORTANT– we will ring you to book an appointment. If you do not have a telephone, please indicate N/A – an appointment will be sent in the post.</i>					
 Home:		Consent to leave answer phone messages				
		Yes <input type="checkbox"/>				No <input type="checkbox"/>
 Work:		Consent to contact at work				
		Yes <input type="checkbox"/>				No <input type="checkbox"/>
Provide your mobile number and you will receive text message reminders of your appointments						
 Mobile:		I do not wish to receive text reminders <input type="checkbox"/>				
		(consent assumed otherwise)				
Email Address:						
	(by supplying your email; we will assume we have consent to contact you in this way)					
Do you have any special requirements / needs when being contacted, assessed or treated by Podiatry Services?						
Need an Interpreter		Please state language				
Need a Chaperone		Suffer with deafness		Use a Wheelchair		
Other needs		*Please state				
Referrer						
Patient		Carer		Consultant		District Nurse
						Practice Nurse
						INCH
GP		AHP		DSN		Other
						AQP ref
						LOROS
*Please state Name of referrer if other than the patient and relationship if carer						

PODIATRY NEED

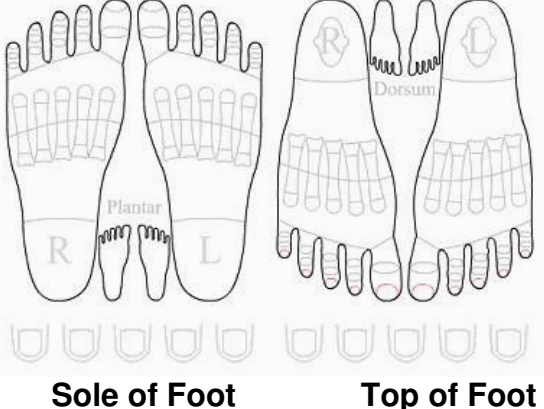
Please give detailed explanations of the current problem(s) you are having

*Please note – the Podiatry Service does NOT provide routine nail cutting
Home Visits are only available if you are completely Bed or Housebound*

[Empty rectangular box for patient input]

Are you having problems with your:											
Right Foot	<input type="checkbox"/>	Left Foot	<input type="checkbox"/>	Both Feet	<input type="checkbox"/>	Toe Nails	<input type="checkbox"/>	Legs	<input type="checkbox"/>	Back	<input type="checkbox"/>
IF Nails, are they	Ingrowing	<input type="checkbox"/>	Thickened	<input type="checkbox"/>	Distorted	<input type="checkbox"/>	Curly	<input type="checkbox"/>			

Please explain what the problem is and indicate on the diagram below where, if on the feet or to do with the nails:



Sole of Foot **Top of Foot**

Are you in pain?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If yes from 1 to 10 how bad is the pain?	<input type="text"/>
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Please describe the pain and when it occurs e.g. when wearing certain shoes or running

<input type="text"/>						
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Have you got an open wound?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
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Do you think you have an infection (not fungal)?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
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If yes, please see your GP as soon as possible as you may need antibiotics.

Is your problem affecting your mobility?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
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If Yes please explain how

<input type="text"/>						
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Ethnic Origin: (please tick one of the boxes below)

White British	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Other Asian Background	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Other Black Background	<input type="checkbox"/>
White & Asian	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Other Mixed Background	<input type="checkbox"/>
White & Black African	<input type="checkbox"/>	African	<input type="checkbox"/>	Other Ethnic Background	<input type="checkbox"/>
White & Black Caribbean	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>		<input type="checkbox"/>
Other White Background	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Prefer not to State	<input type="checkbox"/>

Signature:	<input type="text"/>	Date:	<input type="text"/>
Print Name (if you are not the patient):	<input type="text"/>		

PLEASE NOW COMPLETE THE ATTACHED MEDICAL HISTORY FORM AND RETURN BOTH
Your application cannot be processed without BOTH forms

Leicestershire Partnership 

NHS Trust

Community Health Services

PODIATRY SERVICE MEDICAL HISTORY QUESTIONNAIRE

BOTH FORMS AND ALL DETAILS **MUST** BE COMPLETED SO WE CAN PRIORITISE FOR URGENCY
(Incomplete applications *will* be returned)

NHS NO		TITLE (tick)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SURNAME		FORENAME						
Please answer all the questions. If you answer YES please give more detail, if you answer NO please move to next question								
Do you have Diabetes?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Don't Know <input type="checkbox"/>					
If Yes – what Type	Type I <input type="checkbox"/>	Type II <input type="checkbox"/>	Other* <input type="checkbox"/>					
*Please State:								
How long have you been diabetic?	Years		Recently Diagnosed					
How do you control your diabetes?	Insulin <input type="checkbox"/>	Tablets <input type="checkbox"/>	Both <input type="checkbox"/>	Diet <input type="checkbox"/>				
What was your last HBA ₁ C test result?			When was this taken?					
Do you have heart trouble?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If NO please move on to next question					
Heart attack <input type="checkbox"/>	Angina <input type="checkbox"/>	Heart Failure <input type="checkbox"/>	CHD <input type="checkbox"/>	*Other <input type="checkbox"/>				
*Please State								
Do you have chest trouble?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If NO please move on to next question					
COPD <input type="checkbox"/>	Asthma <input type="checkbox"/>	*Other <input type="checkbox"/>						
*Please State								
Do you have circulation trouble?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If NO please move on to next question					
Peripheral Vascular Disease (PVD) <input type="checkbox"/>	History of Deep Vein Thrombosis (DVT) <input type="checkbox"/>	Stroke <input type="checkbox"/>						
Raynaud's disease <input type="checkbox"/>	History of Chilblains <input type="checkbox"/>	*Other <input type="checkbox"/>						
*Please State								
Do you have bone or joint trouble?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If NO please move on to next question					
Rheumatoid Arthritis <input type="checkbox"/>	Osteo Arthritis <input type="checkbox"/>	Inflammatory Arthritis e.g. Psoriatic <input type="checkbox"/>						
Had any broken bones or fractures to legs or feet (please state below) <input type="checkbox"/>	*Other <input type="checkbox"/>							
*Please State								
Do you have Neurological problems?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If NO please move on to next question					
Neuropathy <input type="checkbox"/>	Paralysis <input type="checkbox"/>	*Other <input type="checkbox"/>						
*Please State								
Do you have any Skin Conditions?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If NO please move on to next question					
Eczema <input type="checkbox"/>	Psoriasis <input type="checkbox"/>	*Other <input type="checkbox"/>						
*Please State								
Do you have Mental Health Problems?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If NO please move on to next question					
Dementia <input type="checkbox"/>	Alzheimer's <input type="checkbox"/>	*Other <input type="checkbox"/>						
*Please State								
Do you have any Allergies?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If NO please move on to next question					
Antibiotics (Please state which ones below) <input type="checkbox"/>	Plasters <input type="checkbox"/>	Latex / rubber <input type="checkbox"/>	*Other <input type="checkbox"/>					
*Please State								
Please Turn Over								
Are you taking any of the following medication?								
Drugs to thin your blood e.g. Warfarin or Aspirin* <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>						
*If YES what are you taking?								

Beta Blockers e.g. Bisoprolol	<input type="checkbox"/>	Statins e.g. Simvastatin	<input type="checkbox"/>	GTN	<input type="checkbox"/>	Inhalers	<input type="checkbox"/>	<input type="checkbox"/>	
Any other type of medication*	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>				
<i>*If YES then please list:</i>									
<i>Have you had any Operations to the following areas? (Please tick all that apply)</i>									
Foot or Feet	<input type="checkbox"/>	Ankle(s)	<input type="checkbox"/>	Leg(s)	<input type="checkbox"/>	Hip(s)	<input type="checkbox"/>	Back	<input type="checkbox"/>
If you have ticked any of the above, please describe what you have had done, which foot / leg, where and why?									
Please list any other operations you have had that you may consider relevant:									
<i>Please provide any other information that you feel might be relevant to us with regards your application for Podiatry Assessment:</i>									

Please Return Both Forms To:
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Lines Open Mon – Fri 9am – 4pm