


<i>For office use only</i>		 <b>NHS Highland</b>
<b>Urgent /Routine/MSK/ B5</b>	Chi.....	
Date referral received		

**NHS Highland Podiatry Service DOES NOT carry out SIMPLE nail cutting**

Each patient will be assessed so an individually tailored management plan can be agreed.  
Treatment may not be given during this initial assessment.

**Please return completed forms to:**

Highland Podiatry Department, 24 Abban Street, Inverness IV3 8HH (Tel. 01463 723250)

**All sections must be completed in BLOCK CAPITALS**

Personal Information					
First name:		M <input type="checkbox"/> F <input type="checkbox"/>	DOB:		
Surname:			Title		
Address:		Please place 'X' in box to indicate your preferred contact	Home		<input type="checkbox"/>
			Mobile		<input type="checkbox"/>
			Work		<input type="checkbox"/>
Post Code		e-mail			<input type="checkbox"/>
GP Practice		Tel No.			

Reason for referral <i>(you can select more than one option)</i>		
Side:	Left <input type="checkbox"/>	Right <input type="checkbox"/> Both <input type="checkbox"/>
Region of the Foot:	Toes <input type="checkbox"/> Heel <input type="checkbox"/> Arch <input type="checkbox"/> Top of Foot <input type="checkbox"/> Sole of Foot <input type="checkbox"/> Side of Foot <input type="checkbox"/> Ankle <input type="checkbox"/>	
Other Lower Limb Regions :	Knee <input type="checkbox"/> Hip <input type="checkbox"/> Back <input type="checkbox"/>	
Structure:	Nails <input type="checkbox"/> Skin <input type="checkbox"/> Muscle/Tendon <input type="checkbox"/> Joint <input type="checkbox"/> Other <input type="checkbox"/> (specify )	
	<b>Yes</b>	<b>No</b>
Is the problem area red?	<input type="checkbox"/>	<input type="checkbox"/>
Is the problem area swollen?	<input type="checkbox"/>	<input type="checkbox"/>
Is the problem area bleeding / discharging / weeping?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking, (or have recently taken), antibiotics for this problem?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Is there any other information you wish to add?</b>		

**Continue overleaf**

How long have you had this problem?

Less than 2 wks       2-12 weeks       3-12 months       Over 1 year

Have you had treatment for this problem before? Yes  No

If Yes please state where and by whom.

**Is the problem causing pain?** Yes  (use X to indicate pain level on scale below) No

<b>No Pain</b>	0	1	2	3	4	5	6	7	8	9	10	<b>Worst Pain Ever</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Do you have Diabetes?** Yes  No

**If YES** please tick the box that represents your foot risk category at your last foot check up.

Low Risk     Moderate Risk     High Risk     Active Foot Disease     Don't Know

I've never had my feet checked

**Please list all other medical conditions**

If **NONE** please tick this box

**Please list all CURRENT MEDICATIONS (attach a prescription tear-off slip if possible)**

If **NONE** please tick this box

**Allergies?** Yes  specify      No

Is the problem preventing you from attending work / school?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you self employed or work for a small company (fewer than 250 people)?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Appointment Support:** If you require communication support please specify below

British Sign Language interpreter  Language interpreter  (language      )

Other  specify.....      **None required**

**Do You Attend Day Care** Yes  Days of week..... No

**Do you have a physical disability?** Yes  Specify      No

**Emergency Contact**

<b>Name</b>		<b>Tel. no.</b>	
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<b>Print name:</b>	<b>Date:</b>
<b>Relationship if completing on behalf of patient:</b>	

**Please note incomplete forms will be returned which may result in a delay in issuing an appointment**