**If you have email access, please return forms to** wi.podiatry@nhs.scot **(if possible including photographs)**

**NHS Western Isles Podiatry Service**

 **Please return completed forms to**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |       | **M** **[ ]  F [ ]**  | **Date of Birth:** |       |  |
| **Address:** |             | **Home** |        |  |
|  |  | **Mobile** |        |  |
|  |  | **Work** |        |  |
| **Post Code** |       | **e-mail** |        |  |
| **GP Practice** |       | **Tel No.** |       |  |
| **Does client have:** | Power of attorney [ ]  Guardianship [ ]  N/A [ ]   |  |

**Why are you referring yourself to Podiatry?**

(Please tick the box which relates to your foot problem)

|  |  |  |
| --- | --- | --- |
| **I have a foot ulcer** | A wound to your foot which may be discharging fluid. Surrounding skin will look normal**(Please note: If infected, surrounding skin may be red, hot, swollen, painful; you may also need to contact your GP)** |  |
| **I am concerned about the circulation in my leg(s)** | One, or both legs have recently, or suddenly, become cold, changed colour or become very painful |  |
| **I am in intense pain** | My foot pain is so bad that I cannot walk properly **(please supply additional details below)** |  |
| **I have an ingrown toenail** | My nail has pierced the flesh and there is discharge from the wound**(Please note: If infected, surrounding skin may be red, hot, swollen, painful; you may also need to contact your GP)** |  |
| **I am in pain** | You have daily foot or ankle pain which is annoying but not disabling **(please supply specific details below)** |  |
| **One or more nails is not manageable** | Some of your nails may be extremely thick, painful, mis-shapen or neglected  |  |
| **I have a painful corn** | You have an area of callus on your foot which is causing discomfort |  |
| **Additional details** | **Please give details if your problem is not described above** (*eg does your foot problem prevent you attending work or carrying out normal daily activities?*) |  |
| How long have you had this problem? Less than 2 wks [ ]  2-12 weeks [ ]  3-12 months [ ]  Over 1 year [ ]  |

|  |  |
| --- | --- |
| **What medical conditions do you have?**  | **(Just write NONE if you have no medical conditions)** |
| **What daily medication do you take?** | **(Just write NONE if you do not take regular medication)** |
| **What allergies do you have?** | **(Just write NONE if you do not have any allergies)** |

|  |  |
| --- | --- |
| **Appointment Support:**   | If you require communication support please specify below |
| **Language Line** [ ]  **None required** [ ]  |
|  |
| **Emergency Contact Name:** |
| **Relationship:** |       | **Tel. no.** |  |
|  |
| **Name of referrer:**       | **Date:** |
| **Relationship if completing on behalf of patient:** |       |