Office Only
Date Received.....
TIARA No: .....
Clinic: .....
Appointment date: .....

Leicestershire Partnership NHS
NHS Trust

Leicestershire County and Rutland
Podiatry Booking Centre
South Wigston Health Centre
80 Blaby Road
South Wigston
Leicester
LE18 4SE
Tel: 0116 2255118

APPLICATION FOR PODIATRY ASSESSMENT

ALL DETAILS **MUST** BE COMPLETED TO ENSURE EFFECTIVE PRIORITISATION

PATIENT NHS NO		**PATIENT TITLE**	MR	MRS	MISS
PATIENT SURNAME		**PATIENT FORENAME**			
Date of Birth		FAMILY GP NAME & ADDRESS			
FULL ADDRESS & POSTCODE		NEXT OF KIN/ CARER CONTACT	Name:		
☎ Work:			Telephone:		
☎ Home:		I do not wish for you to leave a message on my answerphone ☐			
☎ Mobile:		I do not wish to receive text reminders ☐			

(by supplying your contact numbers; we will assume you are happy to be contacted on those numbers; receive text reminders and for us to leave you a message on an answer phone)

Email Address:

(by supplying your email address; we will assume you are happy to be contacted by this method)

To be completed by Referrer:

Please complete if the patient is on an 18 week pathway and you are referring them for definitive treatment

18 WEEK CLOCK START DATE: PPI:

RTT PATHWAY YES ☐ NO ☐

PODIATRY NEED

Please explain the current problem you are having with your foot/feet:

MEDICAL HISTORY

Please indicate if you have any of the following:

Diabetes ☐ Rheumatoid Arthritis ☐ Lower limb amputation ☐

Do you have any medical conditions/illnesses or disabilities?
If so, what are they? (e.g. high blood pressure, heart condition, communication difficulties, severe mobility problems, dementia)

Current Medication (please state)

Do you have any known allergies e.g. latex? (please state)

Have you had, or are you waiting for any operations or medical tests? (please state)

Please indicate if any of the following would affect you if the Podiatry Service needs to make contact.

Deafness Y / N Interpreter Y / N If 'Y' please state which language

Do you have any specific or special requirements or needs when being assessed/treated by Podiatry Services e.g. chaperone?

Referrer (Please circle)

Patient Carer Consultant District Nurse Practice Nurse

General Practitioner Allied Health Professional

(If applicable):	Referring GP/Consultant	GP/Consultant Address:	Date of Next O/P Appointment

Signature: **Date**:

Print Name (if you are not the patient):

Ethnic Origin: (please tick one of the boxes below)

White British		Indian		Other Asian Background	
White Irish		Pakistani		Other Black Background	
White & Asian		Bangladeshi		Other Mixed Background	
White & Black African		African		Other Ethnic Background	
White & Black Caribbean		Caribbean			
Other White Background		Chinese		Prefer not to State	