


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

**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:**

Podiatry Department, Cowal Community Hospital, 360 Argyll Street, Dunoon, PA23 7RL

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

Personal Information			
Name:		M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth: <input style="width: 80%;" type="text"/>
Address:		Please place 'X' in box to indicate your preferred contact number	Home <input type="checkbox"/>
			Mobile <input type="checkbox"/>
			Work <input type="checkbox"/>
Post Code		e-mail	<input style="width: 80%;" type="text"/>
GP Practice		Tel No.	<input style="width: 80%;" type="text"/>

Reason for referral <i>(you can select more than one option)</i>		
Foot/Leg: Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/>		
Region: Toes <input type="checkbox"/> Heel <input type="checkbox"/> Arch <input type="checkbox"/> Top of Foot <input type="checkbox"/> Sole of Foot <input type="checkbox"/> Outside of Foot <input type="checkbox"/> Ankle <input type="checkbox"/> 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.....)		
Is the problem area red?	Yes	No
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"/>
Is there any other information you wish to add?		

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  No

Are you self employed or work for a small company (fewer than 250 people)? Yes  No

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

British Sign Language interpreter     Language interpreter  (language.....)

Other  specify      **None required**

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

**Emergency Contact**

<b>Name</b>		<b>Tel. no.</b>	
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**Print name:**      **Date:**

**Relationship if completing on behalf of patient:**

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