**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**

 **Please return completed forms to**

|  |
| --- |
| **Personal Information** |
| **Name:** |  | **M** **[ ]  F [ ]**  | **Date of Birth:** |  |
| **Address:** |  | **Please place ‘X’ in box to indicate your preferred contact number** | **Home** |  | [ ]  |
| **Mobile** |  | [ ]  |
| **Work** |  | [ ]  |
| **Post Code** |  | **e-mail** |  |
| **GP Practice** |  | **Tel No.** |  |
|  |
| **Reason for referral** *(you can select more than one option)* |
| **Foot/Leg:** Left **[ ]**  Right [ ]  Both [ ]   |
| **Region:** Toes [ ]  Heel [ ]  Arch [ ]  Top of Foot [ ]  Sole of Foot [ ]  Outside of Foot [ ]  Ankle [ ]  Knee [ ]  Hip [ ]  Back [ ]  |
| **Structure:** Nails [ ]  Skin [ ]  Muscle / Tendon [ ]  Joint [ ]  Other [ ]  (specify.................) |
| Is the problem area red? | **Yes** | **No** |
| [ ]  | [ ]  |
| Is the problem area swollen? | [ ]  | [ ]  |
| Is the problem area bleeding / discharging / weeping? | [ ]  | [ ]  |
| Are you currently taking, (or have recently taken), antibiotics for this problem? | [ ]  | [ ]  |
| **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 [ ]   |
| **No Pain** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | 4[ ]  | 5[ ]  | 6[ ]  | 7[ ]  | 8[ ]  | 9[ ]  | 10[ ]  | **Worst Pain Ever** |

|  |  |
| --- | --- |
| **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** |
| **Name**  |  | **Tel. no.** |  |
|  |
| **Print name:**  | **Date:**  |
| **Relationship if completing on behalf of patient:** |  |