NHS NUMBER	
ID REF	

PLEASE RETURN COMPLETED FORM TO: YOUR LOCAL PODIATRY CLINIC – DETAILS FOR EACH CLINIC BELOW

NHS Mersey Care NHS Foundation Trust

PODIATRY SERVICE

APPLICATION FORM FOR COMMUNITY PODIATRY ASSESSMENT

Referral Guidelines - Please read before filling in the form

Please complete all sections on both sides of this application form.
Priority will be given to applicants based on the risk and impact of their condition.
Incomplete applications cannot be prioritised and will be returned to the referrer; this may result in a delay to assessment.

PATIENT DETAILS

Surname		**Forename**		**Gender**	M / F
Address inc postcode					
Dob		**GP**			
Age		**Address**			
Tel. No					
Mobile no.					
Email address	@				
Next of kin / Emergency contact no.		**Relationship**			
Carer details					
Do you consent to receiving a text message to remind you of your podiatry appointment date and time?	Yes / No				

We are asking for the following information so that we can ensure we are providing the best health care services to all our patients. The information is kept confidential and will only be used for statistical purposes.

Please indicate your ethnicity from the options below:

Asian or Asian British:	Bangladeshi	Indian	Pakistani	Any other Asian background	
Black or Black British:	Caribbean	African	Any other Black background		
White:	British	Irish			
Dual Heritage	Asian & White	Black African & White	Black Caribbean & White	Chinese & White	Any other dual heritage background
Chinese or Chinese British					
Any other ethnicity (please describe)					
Not stated					

Do you require an interpreter?	**Y**	**N**	**Which language?**	

How do you describe your religion or belief? Please tick one of the following:

Buddhist		Christian		Hindu		Jewish		Muslim		Sikh	
None		Do not wish to disclose		Other (please describe)							

Do you consider yourself to be disabled?	Yes / No
Are you able to attend a clinic for your assessment	Yes / No
If No please give a reason:	
Do you go out for other reasons	Yes / No
If yes how do you travel?	
Do you receive mobility allowance?	Yes / No

Please Note: If you require a home visit for a podiatry assessment this form needs to be countersigned by your GP or other health professional overleaf

PODIATRY SERVICE

NAME OF APPLICANT			
Please list all medical conditions / physical disabilities e.g. diabetes, rheumatoid arthritis, peripheral vascular disease, peripheral neuropathy. If none please state none in box below			
Do you have a foot ulcer?	Yes / No	**Is this a new wound?**	Yes / No
If yes, please describe where			
Please list all your current medications or attach a copy of your prescription list. If none please state none in box below			
Please explain what problems you are having with your feet:			
Person who completed this form please use block capitals			
Name		**Designation eg self GP DN PN. If other please specify eg relationship**	
Signature		**Contact telephone number of referrer**	**Date**

Bootle Health Centre Park Street, Bootle, L20 3RF	0151 247 6000
Sefton Road clinic Sefton Road Liverpool L21 9HE	0151 247 6929
Maghull Health Centre Westway, Maghull, L31 0DJ	0151 247 6800
Netherton Health CentreMarion Square, Netherton, L30 5SP	0151 247 6080
Prince Street Clinic Prince Street, Waterloo, L22 5PB	0151 247 6900
Thornton Health Centre Bretlands Road, Thornton, L23 1TQ	0151 247 6330