For office use only		
Urgent /Routine/MSK/ B5		NHS Highland
Date referral received	CHI.....	**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:
Highland Podiatry Department, 24 Abban Street, Inverness IV3 8HH (Tel. 01463 723250)

All sections must be completed in BLOCK CAPITALS

Personal Information					
First name:		M ☐ F ☐	**DOB:**		
Surname:			**Title**		
Address:		Please place 'X' in box to indicate your preferred contact	**Home**		☐
			Mobile		☐
			Work		☐
Post Code		**e-mail**			☐
GP Practice		**Tel No.**			

Reason for referral *(you can select more than one option)*

Side: Left ☐ Right ☐ Both ☐

Region of the Foot:
Toes ☐ Heel ☐ Arch ☐ Top of Foot ☐ Sole of Foot ☐ Side of Foot ☐ Ankle ☐

Other Lower Limb Regions : Knee ☐ Hip ☐ Back ☐

Structure: Nails ☐ Skin ☐ Muscle/Tendon ☐ Joint ☐
Other ☐ (specify)

	Yes	No
Is the problem area red?	☐	☐
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?

Continue overleaf

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 Attend Day Care	Yes ☐ Days of week..... No ☐
Do you have a physical disability?	Yes ☐ *Specify* No ☐

Emergency Contact

Name		**Tel. no.**	

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