NHS Ayrshire & Arran

PODIATRY - SELF REFERRAL FORM

IMPORTANT : **Please ensure you read and understand all information given in this form before completion**

When completing the form ALL sections must be completed

Ensure you tick all boxes and answer all questions. This helps identify your foot health need(s), thus ensuring you are given an appropriate Podiatry appointment. If the form is not fully completed we may return it to you requesting more details and/or information.

If you require the form in another language or format, please let us know by telephoning : 0800 169 1441

Before completing this form, please note that the Podiatry Service do not undertake toenail cutting, simple nail care or basic footcare – see further information below:

The **Scottish Government Personal Footcare Guidance** now states that treatments such as toenail cutting, simple nail care and/or basic footcare are no longer provided by NHS Podiatry Services.
This guidance document is available to read online via:
www.gov.scot/publications/personal-footcare-guidance

You may wish to refer to the NHSAA Podiatry website for more information on self-management via:
www.nhsaaa.net/allied-health-professionals-ahps/podiatry

Alternatively you may wish to seek help from other agencies providing personal footcare.

PERSONAL INFORMATION AND CONTACT DETAILS

Name			
Address			
Postcode		**Date of Birth**	
Telephone Number (including area code)		**Mobile Number**	
Email Address			
GP / GP Practice			

1.	**Please provide details about your foot complaint and the reason for referral to the Podiatry Service.** **This section MUST be completed or the form will be returned for more information and delay your application.**

2.	**Do you currently have a foot wound?**	**YES**		**NO**	
3.	**Are you currently taking antibiotics for this foot/nail problem?**	**YES**		**NO**	
4.	**Does this problem cause you any pain?**	**YES**		**NO**	
	If YES please circle the number that best indicates your pain level on the pain-scale below:				

1	2	3	4	5	6	7	8	9	10
LOW PAIN									**SEVERE PAIN**

MEDICAL INFORMATION

4.	**<u>MEDICAL CONDITIONS</u>** Please provide a full list of all diagnosed health conditions you have.				
5.	**Have you been diagnosed with DIABETES?**	**YES**		**NO**	
6.	**If you currently take any medication(s), prescribed by your GP, please list them below:** Alternatively you can enclose a copy of your repeat prescription list with this form.				
7.	**If you currently take or use any homeopathic and/or natural treatments and remedies, please list them below:**				
8.	**Have you attended or received treatment from the Podiatry Service previously?**	**YES**		**NO**	
	If YES is this referral for the <u>same</u> Podiatry problem as before?	**YES**		**NO**	

Please ensure your contact details are correct as your initial appointment may be via Telephone or Video Consultation.

Patient Signature		**Date**	

If you are completing this form on behalf of someone else :

Is the patient aware that you are submitting this form on their behalf?	**YES**		**NO**	

Please provide your details below:

Name		**Relationship to Patient**		**Date**	

Please return the completed form to the following address:

AHP RMC, OT Corridor, Main Building, Ailsa Hospital, Ayr, KA6 6AB