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**NHS SHETLAND PODIATRY SERVICE**

**ASSESSMENT & REFERRAL MATRIX (IN-PATIENT)**

SURNAME............................. ......FORENAME................................. KNOWN AS................................... TITLE..............

DATE OF BIRTH.................... CHI............................ REGISTERED HEALTH CENTRE.....................................................

ADDRESS......................................................................................................................................................................... ........................................................................................................................................POSTCODE.............................

TEL NOS. (H)......................... (W)............................. (M)...............................E-MAIL.................................................... NEXT OF KIN................................. (H)......................... (W)..................... (M)....................... EMAIL.............................. (BY SUPPLYING THESE CONTACT DETAILS WE ASSUME WE HAVE CONSENT TO CONTACT PATIENT THIS WAY)

BED/HOUSE BOUND **YES**  **NO**  POTENTIAL RISK TO STAFF **YES**  **NO**  WARD......................................

**THE PODIATRY SERVICE DOES NOT OFFER A NAIL CUTTING SERVICE IN THE ABSENCE OF RELEVENT MEDICAL/PODIATRIC NEED.**

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| **MEDICAL NEED(**Indicate those relevant to patient)  General good health  Diabetes  Rheumatoid/Inflammatory Arthritis  Poor circulation (resulting in cramp/pain in legs when walking)  Peripheral Neuropathy |

**MEDICATION** (Please list **all** prescribed medicines)

**ALLERGIES** (please list any allergies) NONE

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| **FOOT HEALTH** (PLEASE TICK ALL THOSE THAT APPLY)  Foot ulcer  Foot/toe infection (requiring antibiotics)  Trauma  Pain in feet/ankle/legs (when walking/running/exercising) Gangrene  Ingrown toe nail  Painful corns  General foot pain  Heel pain  Knee pain  Ankle pain  Sports Injury  Thick painful hard skin  Diabetic foot assessment  Painful Thickened Nails  Amputation of leg/foot/toe (Indicate reason for amputation)............................................................. |

**PODIATRY NEED.**

Please give a brief description of why the patient requires podiatry assessment/treatment.

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How long has the patient had this problem?.........................................................................

Are the symptoms worsening? Yes  No  Improving  Same

Is the patient unable to work or care for a dependant because of this problem Yes  No

Has the patient received NHS podiatry treatment in the last 6 months? Yes  No

**TO ASSIST CLINICAL TRIAGE AND ASSESSMENT IT IS ADVISED TO TAKE AND ATTACH PHOTOGRAPH OF FOOT PROBLEM AND SEND WITH THIS FORM ELECTRONOICALLY (e-mail) TO : shet.podiatry@nhs.scot**

Signature of referring healthcare professional.............................................................. Date......................................

Print name.......................................................................................................................................................................

**PLEASE SEND COMPLETED FORM WITH PHOTOGRAPHS TO:** [**shet.podiatry@nhs.scot**](mailto:shet.podiatry@nhs.scot)

**or**

**PODIATRY SERVICES, LERWICK HEALTH CENTRE, SOUTH ROAD, LERWICK, ZE1 0RB.**

Version 3 Nov 2020

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| **FOR OFFICE USE ONLY**  **Date received................................................**  **First appointment date...................................**  **First appointment location..............................**  **CHI …………………………………..** |