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**NHS SHETLAND PODIATRY SERVICE**

**ASSESSMENT & REFERRAL MATRIX (OUT-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** [ ]

**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 ASSESSMENTIT IS ADVISED TO TAKE AND ATTACHPHOTOGRAPHOF FOOT PROBLEM AND SEND WITH THIS FORMELECTRONICALLY (email) TO :** **shet.podiatry@nhs.scot**

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

Print Name.......................................................................................................................................................................

**PLEASE SEND COMPLETED FORM WITH PHOTOGRAPH TO:** **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 …………………………………………..** |