Whittington Health NHS

PODIATRY SELF-REFERRAL FORM

PLEASE NOTE: GP must be in ISLINGTON area.

Please complete this form in as much detail as possible and **post OR email** to:

Post: Central Booking Service (CBS) Level 4, Highgate Wing Dartmouth Park Hill London N19 5JG	**Email:** arti.centralbooking@nhs.net

NHS NUMBER (if known): NHS Number		Today's Date: Short date letter merged
Title: Title	First Name: Given Name	Surname: Surname
Address: Home Full Address (stacked)		DOB: Date of Birth
		Postcode: Home Address Postcode
Home Phone no: Patient Home Telephone	Work phone no: Patient Work Telephone	Mobile Phone no: Patient Mobile Telephone
GP name and Practice: Usual GP Full Name , Usual GP Full Address (stacked)		
First Language: Main Language	Ethnicity: Ethnic Origin	
Do you require an interpreter? Yes ☐ No ☐		
Are you house bound? Yes ☐ No ☐		
Please give a brief description of why you need a foot assessment: **Consultations**		
How long have you had this complaint? Days ☐ Weeks ☐ Months ☐ Years ☐		
Are the symptoms worsening? Yes ☐ No ☐		

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Are you off work or unable to care for dependant because of this problem?

Yes ☐ No ☐ Not Applicable ☐

GENERAL HEALTH

Please tick if you have any of the following:

Diabetes	☐	Stroke	☐
Poor circulation	☐	Heart disease	☐
Rheumatoid arthritis	☐	Eczema/psoriasis	☐
Foot/Leg amputation	☐	Foot/Leg ulcers	☐

MEDICATIONS

Please list all medications/tablets you are taking: Please see below attached

FOOT HEALTH

Please tick if you suffer from any of the following:

Infection or ulcer	☐	Heel Pain	☐
Ingrowing toenail	☐	Pain on walking	☐
Painful corns	☐	Verrucae	☐
Thickened nails	☐	Joint pain in feet	☐

Additional Information:

Medication: Medication

Allergies: Allergies

Problems: Problems