ANGUS LHCC PODIATRY SERVICE

SELF REFERRAL FORM FOR PODIATRY ASSESSMENT

Please complete in BLOCK CAPITALS

Patient D.O.B. ..... CHI..... (office use)

Title ..... Forename ..... Surname .....

Address .....

Post Code ..... Tele. No. .....

Name of GP ..... Surgery Address .....

Is patient totally housebound YES ☐ NO ☐

If you are not totally housebound (i.e. can attend doctor, hairdresser or go to shops) then a clinic appointment will normally be given

Please tick which categories apply:

Physical Disability Which has a direct adverse effect on feet	☐	Diabetes	☐	Over 65 years	☐
Mental Illness (in patient Sunnyside or Social Services client)	☐	Chronic Degenerative Neurological disease	☐	Expectant Mother	☐
Nail Removal	☐	Rheumatoid disease	☐	School Child	☐

Other (please specify) .....

Relevant Medical History/Medication:.....

History MRSA ☐ HIV/Hepatitis ☐

Does this patient's current medication include any of the following:

Long term anti coagulants i.e. Warfarin ☐	Steroids (excl inhalers and topical preparations) ☐	Immuno-suppressive therapy ☐

Brief Outline of Problem .....

Signed ..... Date .....

FOR OFFICE USE ONLY

Priority ☐ Waiting List ☐ Signature .....