

**Private and confidential
Department of Podiatry
Request for treatment**

Title:	Surname:	First names:
Date of birth:	NHS number: (this is 9-10 digits long and there are no letters – ask at your GP surgery if you can't find it)	
Address:		Phone number(s):
Postcode:		Home:
		Work:
		Mobile:
Name and address of your doctor:		Name and phone number of someone we can contact in an emergency:
Specific communication needs (for example, large font, braille, interpreter etc.):		

Reason for referral (tick if appropriate)

Please note that Podiatry has a strict criteria. You must have a high risk medical condition along with a foot problem in order for this referral to be triaged.

If you are referring for multiple conditions, please confirm which is the most urgent as we may not be able to offer treatment for all of your foot problems.

Pain <input type="checkbox"/>	Infection <input type="checkbox"/>	Corns / callus <input type="checkbox"/>	Ingrowing toenail <input type="checkbox"/>
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Describe your foot problem in as much detail as possible:	
How long have you had the problem?	Have you previously been discharged from the Podiatry Services and how has your condition changed?
Medical problems: (for example, Diabetes, Rheumatoid arthritis)	Medication: (prescribed or shop bought)

Do you give your consent for us to do any of the following:	Yes ✓
Leave messages on your answer phone	<input type="checkbox"/>
Leave messages with another member of your household	<input type="checkbox"/>
Allow another person to make appointments for you or confirm appointment times or dates	<input type="checkbox"/>
Access your summary care record (the NHS electronic database)	<input type="checkbox"/>
Share information with your GP or other NHS healthcare providers	<input type="checkbox"/>
Contact you by text message	<input type="checkbox"/>

We are required to collect ethnicity and sexual orientation information for all our service users. Please tick the ethnic group that applies to you.

White	A	British	<input type="checkbox"/>	Black or Black British	M	Caribbean	<input type="checkbox"/>
	B	Irish	<input type="checkbox"/>		N	African	<input type="checkbox"/>
	C	Any other white background	<input type="checkbox"/>		P	Any other Black background	<input type="checkbox"/>
Mixed	D	White and Black Caribbean	<input type="checkbox"/>	Other Ethnic	R	Chinese	<input type="checkbox"/>
	E	White and Black African	<input type="checkbox"/>		S	Any other ethnic category	<input type="checkbox"/>
	F	White and Asian	<input type="checkbox"/>		T	Gypsy/Traveller	<input type="checkbox"/>
	G	Any other mixed background	<input type="checkbox"/>		Are there any cultural or religious considerations we need to be aware of when planning your treatment? If yes, please give details:		
Asian and British Asian	H	Indian	<input type="checkbox"/>				
	J	Pakistani	<input type="checkbox"/>				
	K	Bangladeshi	<input type="checkbox"/>				
	L	Any other Asian background	<input type="checkbox"/>				

Please tick the sexual orientation group that applies to you.

A	Heterosexual	<input type="checkbox"/>	C	Lesbian	<input type="checkbox"/>	E	I decline to answer	<input type="checkbox"/>
B	Homosexual	<input type="checkbox"/>	D	Transgender	<input type="checkbox"/>			

You are welcome to bring someone with you to your appointment but you should bear in mind you will be asked details about your health problems and you may not wish to discuss these in front of your companion. There are no changing rooms at any of our clinics.

Signed..... Date.....	Please return the completed form by post or email to: Podiatry Administration Office, Queen Victoria Memorial Hospital, Herne Bay, Kent, CT6 6EB Or email: kentcft.podiatryreferrals@nhs.net
We may offer you an appointment at another clinic if it has a shorter waiting list. Please tick the box if this is not convenient for you. I am not willing to travel <input type="checkbox"/>	