Podiatry department (South)

Manchester Local Care Organisation
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Application for treatment

Referral Guidelines – Please read before completing this form

All sections of this form must be completed or the form will be returned

The NHS Podiatry department is a medical service that provides treatment to people who have a medical condition that can affect their feet or who require nail surgery, gait analysis or those with a foot disorder which is assessed by the podiatrist as requiring treatment.

We are **unable** to provide treatment for simple nail cutting for people who are otherwise well, corns and callus caused by badly fitting footwear, and other non-painful foot conditions unless this would lead to a serious foot problem if not seen by a podiatrist.

Your application will be triaged and you will be contacted regarding an appointment.

Personal details

Surname	Mr.	Mrs.	Miss	Ms	Other
Forenames		Date of Birth ……. / ……. / …..			
Gender Male ☐ Female ☐ Prefer not to say ☐ Prefer to self describe					
Address					
		Post code			
Email address @					
Telephone Number	**NHS Number**				
GP Name					
Name of GP Practice					

Please tick the box to indicate which clinic you would like to attend and return the form to Northenden Health Centre at the address below or mft.southmanchester.podiatry@nhs.net

Brownley Green H.C. Brownley Road Benchill M22 4GA		Forum Health Simonsway Wythenshawe M22 5RX		Northenden H.C. 489 Palatine Road Northenden M22 4DH	
Burnage H.C. 347 Burnage Lane Burnage M19 1EW		Withington Clinic 535 Wilmslow Road Withington M20 4BA		Withington Community Hospital, Nell Lane West Didsbury M20 2LR	
Treatment at home A limited service is available to people who are **totally housebound** Please tick if required					

Health information – please provide as much information as possible

Do you have or receive treatment for any of the following? ***(Circle correct answer)***

Diabetes	Yes / No
Rheumatoid arthritis	Yes / No
Poor circulation (diagnosed)	Yes / No
Immune disorders (Including chemotherapy and radiotherapy)	Yes / No

Please list all other medical conditions you have or that your have received treatment for in the past

Do you have a communication/ support need **Y / N please give details**

List all your medication

Describe your foot problems for which you require treatment - please be as specific as possible as this will help us to send you to the correct clinic and avoid delays.

Corns / callous □

Ingrowing toe nail □

Foot ulcer □

Current foot Infection e.g. open wound with discharge □

Problem with the way you walk / pain on walking / history of injury to foot/ leg / foot function □

Please describe the condition

Have you seen anyone else for treatment for this condition if "yes" please say who you saw e.g. Physio, GP etc

Ethnic origin (We are required to record this information which will be treated confidentially) Tick correct box

Bangladeshi		Chinese		Irish		Vietnamese	
Black British		East African Asian		Middle Eastern		White British	
Other Black		Other African		Pakistani		White Other	
Caribbean		Indian		Somali		Other	
I do not wish to disclose my ethnic background							

I confirm that the information given above is correct and I wish to receive a podiatry assessment/treatment

Signature of applicant or guardian …… Date …... / ….. / 20..…

Name of Health Care Professional if referring on patients behalf ……..

Is patient aware of the referral? Yes / No