

Podiatry Services

Referral For Assessment, & Treatment If Appropriate

Patient's Name..... DOB.....

Address..... CHI No.....

..... Unit No.....

Post Code..... Tel. No.....

GP/Practice..... Tel. No.....

Address..... Post Code.....

Reason For Foot Health Assessment:

Previous Foot Care & Treatment:

Medical History (Please tick box/boxes):

Diabetes Osteo-Arthritis Any Allergies?.....

Rheumatoid Arthritis Stroke

Any other medical condition (please specify):.....

Medication (Please list all prescribed medication you are currently taking:

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

FOR OFFICE USE ONLY

Date Received: _____ GP Practice: _____

CHI No: _____

Return to: _____ Telephone: _____ Fax: _____