For office use only		
MPI		NHS Highland
Urgent / Routine / MSK	Chi	Location code
Date referral received		

NHS Highland Podiatry Service DOES NOT carry out SIMPLE nail cutting

Each patient will be assessed so an individually tailored management plan can be agreed.
Treatment may not be given during this initial assessment.

Please return completed forms to:
Highland Podiatry Centre, 24 Abban Street, Inverness, IV3 8HH (Tel. 01463 723250)

All sections must be completed in BLOCK CAPITALS

Personal Information				
Name:		M ☐ F ☐	**Date of birth:**	
Address:		**Telephone numbers**	**Home**	
			Mobile	
			Work	
Postcode:		**e-mail**		

GP Information			
GP Practice		**Tel. no.**	

Emergency Contact			
Name		**Tel. no.**	

Appointment Support:	If you require communication support please specify below

British Sign Language interpreter ☐ Language interpreter ☐ (language .....)

Other ☐ *specify*..... **None required** ☐

Do you have a physical disability?	Yes ☐ *Specify*	No ☐

Reason for referral *(you can select more than one option)*	Side: Left ☐ Right ☐ Both ☐

Region:
Toes ☐ Heel ☐ Arch ☐ Top of Foot ☐ Ankle ☐ Knee ☐ Hip ☐ Back ☐

Structure:
Nails ☐ Skin ☐ Muscle/Tendon ☐ Joint ☐ Other ☐ (specify .....)

Is the problem causing pain? Yes ☐ *(use X to indicate pain level on scale below)* No ☐

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Ever**

Continue overleaf

Reason for referral *(Please complete the relevant boxes below)*	**Yes**	**No**
Is the problem area red?		
Is the problem area swollen?		
Is the problem area bleeding / discharging / weeping?		
Are you currently taking, (or have recently taken), antibiotics for this problem?		

How long have you had this problem?

Less than 2 wks ☐ 2-12 weeks ☐ 3-12 months ☐ Over 1 year ☐

Have you had treatment for this problem before? Yes ☐ No ☐

If Yes please state where and by whom. .....

Do you have Diabetes? Yes ☐ No ☐

If YES please tick the box that represents your foot risk category at your last foot check up.

Low Risk ☐ Moderate Risk ☐ High Risk ☐ Active Foot Disease ☐ Don't Know ☐

I've never had my feet checked ☐

Please list all other medical conditions

If **NONE** *please tick this box* ☐

Please list all CURRENT MEDICATIONS ***(attach a prescription tear-off slip if possible)***

If **NONE** *please tick this box* ☐

Allergies?	Yes ☐ *specify*	No ☐

Is there any other information you wish to add?

Is the problem preventing you from attending work / school?	Yes ☐	No ☐
Are you self employed or work for a small company (fewer than 250 people)?	Yes ☐	No ☐

Print name:	**Sign:**
Date:	
Relationship if signing on behalf of patient:	

Please note incomplete forms will be returned which may result in a delay in issuing an appointment