Office Only
Date Received……
TIARA No: ……..
Clinic: ……..
Appointment date: ……

Leicestershire Partnership NHS
NHS Trust

Community Health Services Division

Please Return To:
Podiatry Service Call Centre
South Wigston Health Centre
80 Blaby Road
South Wigston
Leicester
LE18 4SE
Tel: 0116 2255118
Fax : 0116 2255122

Provide your mobile number and we will text reminders of your appointments
Evidence shows that patient's who receive text reminders are less likely to miss appointments; reducing wasted time and money and helping us to provide a more efficient Service.

APPLICATION FOR PODIATRY ASSESSMENT

ALL DETAILS **MUST** BE COMPLETED TO ENSURE EFFECTIVE PRIORITISATION
(Incomplete applications may be returned)

PATIENT NHS NO		**PATIENT TITLE** (please circle)	MR	MRS	MISS
PATIENT SURNAME		**PATIENT FORENAME**			
Date of Birth		**FAMILY GP NAME & ADDRESS**			
FULL ADDRESS		**NEXT OF KIN/ CARER CONTACT**	Name:		
POSTCODE			Telephone:		
TELEPHONE	***IMPORTANT – as we will ring you to book your appointment. If you do not have a telephone please indicate N/A – an appointment will be sent in the post.***				
☎ Home:		**Consent to leave answer phone messages** Yes ☐ No ☐			
☎ Work:		**Consent to contact at work** Yes ☐ No ☐			
☎ Mobile:		**I do not wish to receive text reminders** ☐ (consent assumed otherwise)			
Email Address:					
	(by supplying your email; we will assume we have consent to contact you in this way)				

To be completed by *GP / Consultant Referrer* if on 18 weeks pathway :

Please complete if the patient is on an 18 week pathway and you are referring them for definitive treatment	18 WEEK CLOCK START DATE:			PPI:	
	RTT PATHWAY	YES		NO	

PODIATRY NEED
Please explain the current problem you are having with your foot/feet:

MEDICAL HISTORY
Please indicate if you have any of the following:

Diabetes		**Rheumatoid Arthritis**		**Lower limb amputation**		

Do you have any medical conditions / illnesses or disabilities?
If so, what are they? (e.g. high blood pressure, heart condition, communication difficulties, severe mobility problems, dementia)

Current Medication (please state)

Do you have any known allergies e.g. latex? (please state)

Have you had, or are you waiting for any operations or medical tests? (please state)

Do you have any specific or special requirements / needs when being contacted, assessed or treated by Podiatry Services?

Need an Interpreter	Yes		No		If yes state language				
Need a Chaperone	Yes		No		Suffer with deafness	Yes		No	
Use a Wheelchair	Yes		No		Have any other needs	Yes*		No	

*Please state

Referrer

Patient		Carer		Consultant**		District Nurse		Practice Nurse		**INCH**	
GP**		AHP		DSN		Other*		AQP ref*		Loros	

*Please state

**Referring GP / Consultant Name (Print)	Address:	Date of Next O/P Appointment

Signature:		**Date**:	
Print Name (if you are not the patient):			

Ethnic Origin: (please tick one of the boxes below)

White British		**Indian**		**Other Asian Background**	
White Irish		**Pakistani**		**Other Black Background**	
White & Asian		**Bangladeshi**		**Other Mixed Background**	
White & Black African		**African**		**Other Ethnic Background**	
White & Black Caribbean		**Caribbean**			
Other White Background		**Chinese**		**Prefer not to State**	