August 2023

PODIATRY SERVICES SELF REFERRAL FORM

IMPORTANT:
Please ensure you read and understand all information given in this form before completion. You may wish to ask somebody that you know to help you read and complete this form.

If you require the form in another language or format, please let us know by telephoning : 0800 169 1441

When completing the form ALL sections must be completed

Ensure you tick all boxes and answer all questions. This helps identify your foot health need(s), thus ensuring you are given an appropriate Podiatry appointment. If the form is not fully completed we will return it to you requesting more details / information.

PERSONAL INFORMATION AND CONTACT DETAILS

Name			
Address			
Postcode		**Date of Birth**	
Telephone Number (including area code)		**Mobile Number**	
Email Address:			
GP / GP Practice			

1.	**Is your referral a request for TOENAIL CUTTING?**	**YES**		**NO**	

If you answered YES :

The Scottish Government Personal **Footcare Guidance** states that treatments such as **toenail cutting / simple nail care / basic footcare** have not been provided by NHS Podiatry Services since 2013.
www.gov.scot/publications/personal-footcare-guidance

You may wish to refer to the NHS Ayrshire & Arran Podiatry website for more information on self-management with link to voluntary organisations in your area providing toenail cutting.
https://www.nhsaaa.net/allied-health-professionals-ahps/podiatry/

Alternatively you may wish to seek help from local private podiatry providers who also provide toenail cutting
https://cop.org.uk **"find a Podiatrist"**

2.	**Please provide details about your foot complaint and the reason for referral to the Podiatry Service.** **This section MUST be completed or the form will be returned for more information and delay your application.**

	Continued:

3.	**Do you currently have a foot wound?**	**YES**		**NO**	
	Are you currently taking antibiotics for this foot / nail problem?	**YES**		**NO**	

MEDICAL INFORMATION

4.	**<u>MEDICAL CONDITIONS</u>** **Please provide a full list of any diagnosed health conditions you may have :**				
5.	**If you currently take any medication(s), prescribed by your GP, please list them below :** Alternatively, please enclose a copy of your repeat prescription list with this form.				
6.	**Have you attended and/or had treatment with the Podiatry Service before?**	**YES**		**NO**	
	If YES, is this the <u>same</u> podiatry foot health problem as before?	**YES**		**NO**	

Please ensure your contact details are correct as your initial appointment may be via Telephone or Video Consultation.

Patient Signature		**Date**	

If you are completing this form on behalf of a patient please provide your details below:

Name		**Relationship to Patient**		**Date**	

Is patient aware that you submitting this form on their behalf? **YES** **NO**

Please return this completed form to the following address:

AHP Referral Management Office
Ground Floor
Biggart Hospital
Biggart Road
PRESTWICK
KA9 2HQ

If you wish to enquire about a Podiatry referral or a Podiatry appointment, please telephone :

01563 826361

Mon-Fri / 9.00am-12.30pm / 1.00pm-3.00pm