South Eastern Health and Social Care Trust

Podiatry Self Referral Form

In order to assess your need for Podiatry treatment, please give as much information as possible. Thank you.

Surname:	**Date of Birth:**
Forename(s):	**GP Name:**
Address: **Postcode:**	**GP Address:** **Postcode:**
Contact Telephone Numbers: Home:	**Work:** **Mobile:**

REASON FOR REQUESTING PODIATRY TREATMENT

Arch Pain	☐	Bunion Pain	☐	Corn	☐
Difficulty cutting nails	☐	Hard Skin	☐	Heel Pain	☐
Ingrowing toenails	☐	Verucca	☐	Other, please state	☐

MEDICAL CONDITIONS (AS DIAGNOSED BY YOUR G.P.)

Alzheimers/Dementia	☐	Circulatory Disease	☐	Diabetes	☐
Renal Disease	☐	Learning Disability	☐	Osteoarthritis	☐
Multiple Sclerosis	☐	Parkinsons Disease	☐	Registered Blind	☐
Rheumatoid Arthritis	☐	Stroke	☐	Other, please state	☐

CURRENT MEDICATION

Anti Coagulants Warfarin)/(Plavix) ☐ Steriods ☐ Other, please state or attach list ☐

Have you been prescribed a course of antibiotics for your foot problems in the past month?

Yes ☐ No ☐

Signature _____Date _____

Please complete the above sections and return this form to:

Official Use:

Application Received	Category: E / U / Non urgent (Clinic)	Non Urgent (Health Education)
Referral Code	Location of Assessment	