**PODIATRY REFERRAL**

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| **CARE HOMES** | |
| **NAME AND ADDRESS**  **OF CARE HOME**  **Tel. No.** | |
| **Patient Details**  Male/Female *Please delete as appropriate*  CHI No.  Mr/Mrs/Miss:  First Name:  Surname:  Known As  DOB: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has patient been assessed by the  Care homes Podiatrist in the last 12 months  Yes No | **Risk Factors** |
|  | No  Yes  (If yes please specify below or contact Podiatry Office)  Are there any risk factors for staff? |
| **GP Details** |
| Name:  Practice:  Practice Code: |
| **Medical History (Inc.Allergies)** | **Medication** |
|  |  |
| **Reason for Referral** |
|  |
| Referred by: Signature: Date : N.B. Referrals must be signed by a senior carer | |
| Emergency Urgent Non Urgent N.B. Only Neuropathic or Ischaemic Ulceration **will be classed as an emergency referral**  Please send referral to: Podiatry Headquarters, Clackmannanshire Community Health Care Centre, Hallpark, Sauchie, FK10 3JQ (T) 01324 567950 email: [FV.PDPRO@nhs.scot](mailto:FV.PDPRO@nhs.scot) using subject [secure] referral | |
| For Office Use Only | |
| Date referral received: Caseload assigned to: | |