

Podiatry services
Application for treatment

NHS podiatry treatment is available to those people registered with a South Manchester GP with a clinical need.

Referral Guidelines – Please read before completing this form

The NHS Podiatry service is a medical service. Treatment will only be given to people with a medical condition affecting their feet, those requiring nail surgery, those requiring gait analysis or those with a foot disorder which is assessed by the podiatrist as requiring treatment.

We are unable to provide treatment for simple nail cutting, corns and callus caused by badly fitting footwear, and non-painful foot conditions unless this would lead to a serious foot problem if not seen by a podiatrist.

Your application will be triaged and you will be contacted regarding an appointment.

Personal details

Surname		Mr.	Mrs.	Miss	Ms
Forenames		Date of Birth / /			
Address					
				Postcode	
Telephone Number			NHS Number		
GP Name					
Practice Address					

Please tick in the box to indicate which clinic you would like to attend and return completed form to Northenden HC

Brownley Green H.C. Brownley Road Benchill M22 4GA	<input type="checkbox"/>	Forum Health Simonsway Wythenshawe M22 5RX	<input type="checkbox"/>	Northenden H.C. 489 Palatine Road Northenden M22 4DH	<input type="checkbox"/>
Burnage H.C. 347 Burnage Lane Burnage M19 1EW	<input type="checkbox"/>	Withington Clinic 535 Wilmslow Road Withington M20 4BA	<input type="checkbox"/>	Withington Community Hosp Nell Lane West Didsbury M20 2LR	<input type="checkbox"/>
Treatment at home A limited service is available to people who are <u>totally housebound</u> Please tick if required					<input type="checkbox"/>

Health information

Do you have or receive treatment for any of the following **Diabetes** Yes / No
 (Circle correct answer) **Rheumatoid arthritis** Yes / No
Loss of sensation in your feet Yes / No
Heart disease Yes / No
Poor circulation (diagnosed) Yes / No

Please list all other medical conditions you have or that you have received treatment for in the past

List all your medication

Describe your foot problems for which you require treatment

Ethnic origin (We are required to record this information which will be treated with confidentiality)
 Tick correct box

Bangladeshi	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Irish	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>
Black British	<input type="checkbox"/>	East African Asian	<input type="checkbox"/>	Middle Eastern	<input type="checkbox"/>	White British	<input type="checkbox"/>
Other Black	<input type="checkbox"/>	Other African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	White Other	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Somali	<input type="checkbox"/>	Other	<input type="checkbox"/>
I do not wish to disclose my ethnic background							<input type="checkbox"/>

All sections of this form must be completed or the form will be returned

I confirm that the information given above is correct and I wish to receive a podiatry assessment/treatment

Signature of applicant or guardian Date / / 20

Official use

Received:	Triage:		AQP		Clinic location							Type			
	Urgent	Routine	Yes	No	BU	WC	WCH	NO	BG	FH	DOM	MSK	NS	Paed	NP

Information from telephone triage