Cumbria Partnership NHS
NHS Foundation Trust

Podiatry Referral Form – Allerdale Locality

IF YOU HAVE DIABETES PLEASE CONTACT YOUR NEAREST PODIATRY CLINIC FOR ADVICE ON WHERE TO ACCESS CARE.
ALLERDLE – 01900 705120, CARLISLE – 01228 608020, COPELAND – 01946 68635
EDEN – 01768 245628

Dear Patient, HELP US TO HELP YOU. Please first read the notes on the back page and complete the form in full, giving us as much detail about you're foot problem as you can. If you leave details out, the form may have to be returned to you which would delay the treatment.

Mr/Mrs/Miss/Ms/Master/Other (please Specify).....

Name..... Date of Birth.....

If under 16 Parent/Guardian Name.....

Address.....

.....Post Code.....

Tel No Home..... Work..... Mobile.....

GP Practice.....

Referred by Self/GP/Health Visitor/Practice Nurse/District Nurse/Physio

Other (please specify).....

Other professionals involved in your care .....

Next of Kin ..... Next of kin details .....
Telephone number .....

Ethnic origin (these categories are used in the national census)

White: British ☐ Irish ☐ Other white background ☐

Mixed: White /Black Caribbean ☐ White /Black African ☐
White Asian ☐ Other mixed background ☐

Asian or Asian background: Indian ☐ Pakistani ☐ Bangladeshi ☐

Black: British ☐ Caribbean ☐ African ☐ Other Black background ☐

Other ethnic group: Chinese ☐ Other ☐ Not Stated ☐

Medical History

Please tick if you have any of the following:

Heart Problems ☐ Rheumatoid Arthritis ☐ Kidney Disease ☐

Poor Circulation ☐ Stroke ☐ Diabetes ☐ Neuropathy ☐

Cancer-currently receiving treatment

Other (please state) ----------

Do you consent to the Podiatry service accessing your GP records? Yes / No (circle)

Please list any medicines/tablets that you take, or attach a copy of your current repeat prescription. Please note if this is not filled in the referral could be returned if you do not take medication please state this.

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Have you any allergies? Yes / No Describe.....

What is your foot problem? (Must be completed)

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Are you receiving treatment for this problem elsewhere? Yes/No

Have you been treated by NHS podiatry before Yes/No

If this form is completed by a Health Professional please:-
Sign:-
Name:-
Designation / Contact Details:-

Comments / Further Information

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I confirm I have read / agree to the information attached.

Patients Signature ..... Date.....

Please return completed form to:

Podiatry Department,
Workington Hospital
Park Lane
Workington
Cumbria
01900705120
Podiatry.requests@cumbria.nhs.uk

For Office Use Only

Triage Date .....

Priority: Urgent / Non Urgent

Status: New Patient Bio Paed Diabetic Screening DOM

Referral on / reason why:-

Podiatrists signature.....

Print Name .....

Contact Notes.....

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