***Criteria for Referral for Podiatry Assessment***

**Do you meet the criteria for receiving Podiatry Assessment?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Foot (Podiatric) need** | **Medical need** | **Non-eligible conditions** | **Musculoskeletal Foot Problems** |
| * Ulceration/non healing foot wounds
* Foot infection which has required antibiotic treatment (excluding fungal nails)
* In-growing toenail with inflammation or infection
 | * Neuropathy (loss of feeling in the lower limb due to a medical condition such as diabetes)
* Peripheral Vascular Disease (very poor circulation in the lower limb)
* **Rheumatology***/*inflammatory/autoimmune conditions
* Diabetes (moderate or high foot risk classification)
* Foot ulcers (Diabetic foot ulcers are referred straight to the Diabetic Foot Clinic)
* Neurological Disorders e.g. MS
* Undergoing chemotherapy or on dialysis
* Non traumatic foot/leg amputation (foot and ankle amputation caused by a medical condition)
 | * Simple nail cuts
* Corns and callus in healthy patients
* Fungal nails
* Verrucaes
* Diabetes (low foot risk classification – *Bi-annual checks should be provided in your GP practice)*
 | * Foot pain from Musculoskeletal foot conditions - visit our website at [www.nhsborders.scot.nhs.uk/commonfootandankleproblems](http://www.nhsborders.scot.nhs.uk/commonfootandankleproblems) where there is further information and advice leaflets available.
* Children under 16 with musculoskeletal foot problems-Referrals can be made via Health Professionals including GP’s, Health Visitors and AHP’s or parents can fill in a request for assistance form.
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**Before completing this form, please note that the podiatry service do not undertake toenail cutting, simple nail care or basic foot care in patients who do not meet our criteria. See further information below.**

The Scottish Government defines basic foot care as “part of a personal hygiene routine for feet which covers a set of tasks that an adult, whatever their age, would normally do for themselves if they are able to.”

The guidance document is available at <https://www.gov.scot/publications/personal-footcare-guidance/>. You will find information and resources to help with your personal foot care on the NHS Education for Scotland’s Personal foot care page <http://www.knowledge.scot.nhs.uk/home/portals-and-topics/personal-footcare.aspx>.

**Please send the below form once completed to:**

**AHP Booking Team**

**AHP Support Office (Room 1GW8 )**

**Borders General Hospital**

**TD6 9BS**

Or email to Podiatryadmin@borders.scot.nhs.uk

**PODIATRY APPLICATION FORM**

**ALL sections of this application form must be filled in, failure to do so will result in the application form being returned and may delay assessment.**

**Please also note initial contact will be a near -me (video) consultation or if this is not possible a telephone consultation where you will be assessed and if it is deemed to be necessary, a face to face appointment will be arranged.**

**Title: *Mr/Mrs/Miss/Ms* Forename: Surname:**

**Have you had previous treatment from this service?** **YES/NO**

**Where: How long ago? Is this the same condition? YES/NO**

**Reason for referral, please be specific.** Where the problem is, how long it’s been there, what have you done to try to alleviate the problem before contacting the podiatry department?

**Please indicate the current level of foot pain (if any) where 1 is no pain and 10 is extreme pain\_\_\_\_\_\_\_\_\_**

**Are you taking antibiotics for this problem? YES/NO**

**Do you have an open wound on your foot? YES/NO**

**How long have you had this complaint? DAYS WEEKS MONTHS YEARS**

**Do you weigh more than 25 stones? YES/NO**

**Emergency Contact Name: Telephone No:**

**Email Address: Permission to leave a message on your answerphone**

 **YES/NO**

**Address: GP and Surgery Address:**

**Post Code:**

**D.O.B Tel No: Mobile:**

**Who currently provides foot care? SELF/RELATIVE/CARER/PRIVATE PODIATRIST/OTHER – please specify**

**MOBILITY ASSESSMENT**

Are you fully mobile? **YES/NO**

**A very limited service is available to patients who are totally housebound.\* We may contact your GP for further information regarding this.**

**I require a home visit assessment because (please tick all that apply)**

* **I am bedbound and have a key safe (we may ask for your keysafe number to facilitate visit)**
* **I use a hoist and am unable to travel in a wheelchair taxi**
* **Other –** please state reason

**Definition of housebound:** Patients eligible for a home visit by the podiatry service are those who are one or more of the following:

* Persons who are completely bedbound
* Persons who require hoisting in order to be moved or to travel and would become ill if required to travel to a clinic
* Persons deemed on a temporary basis to be clinically too ill to be reasonably expected to travel

**Medical History:**

**Current Medication:**

**Please tick all that apply:**

**Diabetes Poor circulation to lower limbs RHEUMATOID arthritis**

**On dialysis Amputation (toes or part of foot or lower limb FOOT ulcer**

**Undergoing cancer treatment Other (please specify)**

**SIGNED DATE**