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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please complete this section fully so we can triage the referral appropriately; incomplete referrals will be rejected requesting additional information.** | | | | | | | | | | | | | | | | | | | | | | | |
| Surname | |  | | | | | | | | | | | | | Mr | | | | Mrs | | Miss | Ms | |
| Forename(s) | |  | | | | | | | | | | | | | Date of Birth | | | |  | | | | |
| Address | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | Post Code | | | | |  | | | | |
| Telephone  Home | |  | | | | | Mobile | | |  | | | | NHS No. | | | | |  | | | | |
| Does the patient need an interpreter? | | | | | | | Yes / No | | | | | | | Language | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| GP Name | |  | | | | | | | | | | | | | | | | | | | | | |
| GP Practice Address | |  | | | | | | | | | | | | | | | | | | | | | |
| * **Podiatry assessment involves the development of a treatment plan which may include treatment, self-management, advice, and discharge.** * **If you qualify for treatment, you will be sent an appointment for the clinic with the shortest wait. Services such as nail surgery, wound care and MSK are only offered at specific clinics.** | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical history and Medication** Please ask the GP for a summary of medical history & medication. | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Please list full details of your foot problem** Nail cutting and routine corn / callus treatments will not be undertaken unless the patient meets with relevant medical need. | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Please Turn Over ⏵** | | | | | | | | | | | | | | | | | | | | | | | |
| **Equality and Diversity**  **(This information helps us to make sure we are reaching all groups of people)** | | | | | | | | | | | | | | | | | | | | | | | |
| **Ethnic Background** | | | | | | | | | | | | | | | | | | | | | | | |
| Bangladeshi | | | |  | Chinese | | | |  | | Irish | | | | |  | | Vietnamese | | | | |  |
| Black British | | | |  | East African Asian | | | |  | | Middle Eastern | | | | |  | | White British | | | | |  |
| Other Black | | | |  | Other African | | | |  | | Pakistani | | | | |  | | White Other | | | | |  |
| Caribbean | | | |  | Indian | | | |  | | Somali | | | | |  | | Other | | | | |  |
| I do not wish to disclose my ethnic backbround | | | | | | | | | | | | | | | | | | | | | | |  |
| **Religion** | | | | | | | | | | | | | | | | | | | | | | | |
| Christianity | | | |  | Buddhism | | | |  | | Judaism | | | | |  | | None | | | | |  |
| Sikhism | | | |  | Islam | | | |  | | Other | | | | |  | |  | | | | | |
| I do not wish to disclose my religion | | | | | | | | | | | | | | | | | | | | | | |  |
| **Sexual Orientation** | | | | | | | | | | | | | | | | | | | | | | | |
| Heterosexual / Straight | | | | | |  | | Bisexual | | | |  | Lesbian / Gay Man / Gay Woman | | | | | | | | | |  |
| I do not wish to disclose my sexual orientation | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | |  |
| **NHS Podiatry services are only for patients with relevant medical and podiatric needs.**  **Manchester Local Care Organisation is a teaching organisation and it is possible that your treatment may be undertaken by students.**  **Please complete all sections on both sides of the form or the referral will not be accepted.**  **Incomplete forms will be returned to the referrer.**  **I confirm that I am the patient and the information given in the form is correct. I wish to receive a podiatry assessment appointment and consent to any subsequent informed assessment and treatment.** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Referrer and Designation | | |  | | | | | | | | | | | | | | Date | | |  | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |  | |
|  | **Completed referral forms should be sent to:**  **Podiatry Department**  **Harpurhey Health Centre**  **1 Church Lane, Harpurhey, Manchester, M9 4BE**  **Tel: (0161) 861 2439**  **Email:** [**mft.communitypodiatry@nhs.net**](mailto:mft.communitypodiatry@nhs.net) | | | | | | | | | | | | | | | | | | | | |  | |