Southern Health and Social Care Trust

Quality Care - for you, with you

Podiatry Service – Self Referral Form

Please complete all sections of this form as accurately as possible.

Full completion of this form allows us to identify your foot health needs, enabling us to direct you to the appropriate part of the Podiatry Service. Incomplete applications forms will be returned to you and this will lead to a delay in processing your application. *

All podiatry assessment and treatment will be targeted at your specific foot health problems. When these problems have been resolved or cannot be improved through further podiatry interventions, most patients will be discharged from the service.

PERSONAL DETAILS:

Surname		**Civil Status**			
Forename/s		**D.O.B**		**Sex:**	**M/F**
Address			**Postcode**		
Contact No.		**H&C No**			
Email address:					

NEXT OF KIN DETAILS:

Name		**Day time contact**	
Address			
Relationship			

GP DETAILS:

Practice Name		**Tel No**	
Address			

Interpreter required	**Yes / No**
If Yes, which language is required	

Applicable for Children only.

Please indicate if the Child is: On the Child Protection register / Is a Looked after Child / Is a Child in Need *(Delete as appropriate)*

Reason for Referral: [Specify nature of problem, include any additional relevant risk factor information]

Medical History:

Medication:

Other Relevant Information:

Have you attended the Podiatry Service before: Yes / No
If YES, please specify when.
Are you known to the Community Adult Learning Disability Team: Yes/No

Referrer's signature		**Date**	
Patient / Carer / Parent / Guardian / Health Professional *(Delete as appropriate)*			

***We have eligibility criteria and not everyone will be offered an appointment.**

Return completed form by email to:

ahp.cbu@southerntrust.hscni.net

Or by post to:

AHP Central Booking Unit
Magowan West
11 West Street
Portadown
BT62 3PG