

Tameside Podiatry (Foot protection team) Service Referral form

Referral Criteria

To be eligible for assessment or treatment you should fall into one of the categories below:

High Risk Medical Categories

(Must also be showing signs or symptoms in feet/legs that increase your risk of poor health of your feet or legs)

- **Diabetes/ Rheumatoid Arthritis or Connective tissue disorder** (one or more of the following must be present: neuropathy (damaged nerves to your feet), foot deformity, skin & nail conditions causing pain)
- **Peripheral Arterial Disease** (Reduced blood-flow to your feet or legs)
- **Immuno-suppressed** (may include current chemotherapy, Biologics etc.)
- **Neurological conditions** (directly affecting the feet, for example Cerebral Palsy)
- **Kidney Problems requiring dialysis**
- **On or approaching 'End of Life' care pathway**

We cannot accept referrals for annual diabetic foot assessment, general foot care (hard skin, corns, or nail care) without a clearly indicated risk to the limb.

Acute Podiatric Needs

- Infection, Ulcers/Wounds,
- In-growing toenail- Where nail surgery is appropriate this will be offered. If nail surgery is not required or wanted, self-care will be advised.

Other Podiatric Needs

- Biomechanical Needs- Structural foot problems e.g., foot/ankle pain, associated knee/hip pain or congenital deformities.
- Paediatric Foot/ankle development

Please note: nail care and callus only (unless you fall into the categories above) / fungal nails and verrucae are not accepted by the Podiatry Service.

NHS Podiatry referrals are evaluated based on eligibility criteria.

Please provide as much detail about your medical history and medication

If you are eligible, you will be notified by letter to schedule an assessment, and if you do not respond within 3 weeks, the referral is closed.

Eligible patients will undergo an initial assessment, with the goal of resolving their issue and discharging from the service if appropriate.

Repeat non-compliance may result in early discharge from the podiatry service after a full review of the treatment plan.

Ineligible patients will be informed by letter.

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Name:	NHS No:
Address:	Preferred language: Interpreter required: Yes
Tel / Mob:	Dob:
GP Address:	Emergency contact:

Medical History

- Diabetes
 Peripheral Arterial Disease
 Rheumatoid arthritis

Previous Surgery to legs or feet (please include any previous surgery to improve the circulation (vascular) or orthopaedic surgery):

Other:

Allergies/Sensitivities:

Smoking history: Current Ex-smoker Never

Alcohol history: _____ units/week

Reason for referral:

Ulceration/ Cut to the foot/ Wound dressing

Details:

In-growing Nail that has cut the skin/ weeping / infected

In-growing nail causing pain

Details:

Foot pain/Ankle/Knee pain/ Biomechanical assessment

Heel pain/Plantar fasciitis

Details:

Hard skin (callus)/ Corns Thickened/ Deformed Nails

*** Please include any relevant photos of your foot problem if possible***

Please indicate if a home visit is required. Note: This service is limited and only available for patients who are bedbound or completely housebound (you do not leave the house for any other medical appointments) _____

Return the completed form to the following address: Community Central Booking, Crickets Lane Clinic, Ashton, OL6 6NG

E-mail: communitycentralbooking@tgh.nhs.uk

Telephone No: 0161 922 4888 opt 3

Signature.....

Date.....