Podiatry Services Referral Form 

V5 – July 2023

**For use by Health & Social Care Professionals Only.**

Please consider current referral pathways and Podiatry Services Access Criteria when making this referral. Please call Podiatry Services if you have any queries, on 01752 434855 or email us at livewell.podiatryhub@nhs.net

Please note we **DO NOT** accept referrals for the following:

* personal/simple nail care or fungal nails
* verrucae and all other dermatological conditions including tinea pedis

Insufficient detail will result in your referral being returned to you. MS Word versions of this document can be obtained via the service as detailed above.

|  |
| --- |
| **Helpful Notes to Support You and Your Patient’s Care Needs:** |
| * **Signposting and Access to Self-management and Alternative Provider Information**

The service website has a wide range of self-care and education information covering general foot health issues, diabetes, and musculoskeletal conditions. Details of how to access alternative providers of foot healthcare (non-NHS) are also available on the site.Patient’s who do not meet the threshold for face-to-face care will be triaged for signposting and provided with appropriate written self-management and care advice in the post.Referrers may wish to direct patients themselves to the website for this advice rather than refer: [www.livewellsouthwest.co.uk/project/podiatry](http://www.livewellsouthwest.co.uk/project/podiatry)* **Diabetes**

Only patients with diabetes who have the following will be offered **face-to-face care** by Podiatry Services:* + Current foot ulceration (below level of the malleoli)
	+ Vulnerable, newly healed ulceration
	+ Active case or suspicion of, Charcot Arthropathy
	+ Gangrene
	+ Critical Limb Ischaemia
	+ Spreading infection
	+ **All other patient with diabetes** will be signposted to the service website for self-care, alternative provider information and diabetes foot health education materials. Referrers may wish to direct patients themselves to the website rather than refer: [www.livewellsouthwest.co.uk/project/podiatry](http://www.livewellsouthwest.co.uk/project/podiatry)
* **Diabetes Acute Care**

For **new** diabetic foot wounds, infections, critical ischaemia, gangrene, osteomyelitis or suspected Charcot joints, **have you also sent a referral to the UHPNT Multidisciplinary Foot Team?** They can be contacted via:Email: plhtr.MultiDisciplinaryPodiatry@nhs.net Tel: (01752) 439802Website: <https://www.plymouthhospitals.nhs.uk/diabetespodiatry> - E-referral form available on website * **Note on Surgical or Same Day/Next Day Wound Care**

Please note that the service is not commissioned to provide same or next day wound care such as following hospital discharge, or for any surgical wounds on discharge from hospital. Please refer to the District Nursing Service if you require this service.* **Musculoskeletal (MSK) Referrals to Podiatry:**

If referral is for MSK Podiatry, please complete the separate MSK section labelled below. |
| **Patient Details** |
| Title |  | Address |
| Surname |  |
| Forename(s) |  |
| Date of Birth |  |
| NHS Number |  |
| Telephone No’s | Mobile: | Home: |
| Patient’s Email Address: |  |

|  |  |
| --- | --- |
| **Parental Responsibility (if applicable)** | **Safeguarding** |
| State name of person with Parental Responsibility and address if different to above: | Is there a current Child Protection Plan or Adult Safeguarding arrangement in place? Yes [ ] No [ ]  |

|  |  |
| --- | --- |
| **Referrer Details**  | **GP Name and Address**  |
| Referrer Name: |  |
| Referrer’s Job Title: |
| Address: |
| Telephone Number: |
| Contact Email: |

|  |
| --- |
| **Domiciliary Care Request**  |
| The Service will only visit “at home”, those patients who are **BOTH**:1. Bed/chair bound and/or requires hoisting to travel
2. Has a foot wound below the level of the malleoli (ankle)
 | **Tick this box ONLY if you consider the patient is eligible for domiciliary care** | [ ]  |

|  |
| --- |
| **Vulnerabilities, Risks & Other Needs (please tick all that apply)** |
| [ ]  Learning Disabilities | [ ]  Military Veteran | [ ]  Homeless  | [ ]  Allergies |
| [ ]  Significant mental health issues which might impair engagement with Podiatry Services |
| [ ]  Current or recent history of MRSA, PVL etc |
| Please detail below and provide for any further requirements (for example: transport, days unavailable to attend, translation services, large print documents, chaperone required).  |

|  |
| --- |
| **Medical & Surgical History** |
| **If sending history summary details separately, please tick the box so we know to check for them** | [ ]  |
| Please tick the appropriate box(es) and provide any other information you think may be helpful for us to know – this will help review the patient’s suitability to access the Service:[ ]  Active Foot Ulceration [ ]  Symptomatic Peripheral Arterial Disease e.g. rest pain, intermittent claudication[ ]  Neurological Disorder with lower limb or foot involvement [ ]  Neuropathic Arthropathy (Charcot Foot)[ ]  Amputee: History of lower limb/foot/toes[ ]  Connective Tissue Disease[ ]  Inflammatory Arthropathy WITH foot deformity with lesions[ ]  Other (please list below)  |
| **\* Diabetes Patients.** Please provide the latest HbA1c Test if known: Result: Date: [ ]  Not known |
| **Please tick relevant boxes give a full description of the presenting problem and any other relevant information below:** |
| [ ]  Ulcer/Wound (wound must be below the level of the malleoli, **if at/or above this level, refer to DN Service etc**) [ ]  Infection (excluding fungal skin and nail infections) [ ]  Musculoskeletal Reason[ ]  Toenail with either wound and/or, infection which may require surgical removal[ ]  Callus and/or “Corns”[ ]  Fixed Foot Deformity, or History of Lower Limb Amputation, or Foot/Ankle Surgery[ ]  Other - please provide details below. We **do not** accept referrals for routine toenail cutting including fungal or thickened nails; as these can be managed by the patient, or a family member, a friend or private provider:**Additional details:** |
| * How long has the problem been present?
 |  |
| * Is the problem……
 | [ ]  getting better? | [ ]  getting worse? | [ ]  static/chronic? |
| * Is the patient able to work/continue with their Daily Living Activities?
 | [ ]  Yes | [ ]  No |
| What, if any, treatment has already been given for the problem? |
|  |
| Is there anything else you wish for us to know about the patient’s problem? |
|  |
| **Musculoskeletal (MSK) Referrals (Adults and Child & Young People)** |
| **FOR ADULT and C&YP’s MSK PODIATRY REFERRALS**, please complete the following:**Affected area (tick all that apply):** |
| [ ]  Toes  | [ ]  Forefoot | [ ]  Mid-foot | [ ]  Heel | [ ]  Ankle | [ ]  Lower Leg |
| **For consideration of:** |
| [ ]  | Foot orthoses | [ ]   | Exercise therapy/advice | [ ]   | Footwear advice | [ ]  | Taping | [ ]  | Shockwave Therapy |
| Any other specific treatment being requested?Please provide further detail here such as nature of impact on daily living, details of onset, treatment to date, and if known, diagnoses and imaging results to date. |

|  |
| --- |
| **Photographs to Aid Triage** |
| Photographs can be inserted into this document or sent separately and securely via NHS Mail as detailed at the end of this form. |
| **If sending photographs separately, please tick the box so we know to check for them** | [ ]  |
| Insert your photograph files here: |

|  |
| --- |
| **Referral Sign-Off** |
| Signature  | Date of referral  |
| Printed Name  |
| Job Title:  |

|  |
| --- |
| **Sending Your Referral**  |
| Once completed, please forward electronically to: livewell.podiatryhub@nhs.net Alternatively send a completed paper copy to: Podiatry Services Beauchamp CentreMount Gould Hospital 200 Mount Gould RoadPlymouthPL4 7QD |