Please consider current referral pathways and Podiatry Services Access Criteria when making this referral. Referrals that do not meet the Access Criteria will be returned to the referrer. Please call the Podiatry Service on 01752 434848 if you have any queries. **Once completed, please either:**

|  |  |
| --- | --- |
| **Email to:** | [PCHCIC.Plymouth-Podiatry@nhs.net](mailto:PCHCIC.Plymouth-Podiatry@nhs.net) |
| **Post to:** | Podiatry Referral Management Centre, Nuffield Clinic, 1a Baring Street, Plymouth PL4 8NF |
| **Use Choose and Book:** | GPs only- Please note that appointments cannot be directly booked |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | | | | | | | | | |
| Title | |  | | | | | | **Or**  **Affix Patient Label Here** | | | | | | |
| Surname | |  | | | | | |
| Forename(s) | |  | | | | | |
| Date of Birth | |  | | | | | |
| Address | |  | | | | | |
| NHS Number | |  | | | | | | Ethnicity: | | |  | | | |
| Telephone | | Daytime: | | | | | | Home: | | | | | | |
| **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 (if different)** | | | | | | |
| **Referrer Name:** | | | | | | | |  | | | | | | |
| **Address:** | | | | | | | |
| **Telephone Number** | | | | | | | |
| **Problem Details and current treatment modalities (use additional sheet if required)** | | | | | | | | | | | | | | |
| **Off work due to problem 🞎** | | | | **Known Risks to Others 🞎** | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Patient Name:** | | | | | | | **NHS Number:** | | | | | | | |
| **Current Medication- Repeat and Acute- or attach Summary print-out** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Medical History- or attach Summary print-out** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Domiciliary Care: Please tick box if required noting Eligibility Criteria below** | | | | | | | | | | | | | | |
| The Service will only see in the Domiciliary setting those who are bedbound 24/7, require hoisting, live in a **nursing** home or secure establishment, or are temporarily too ill to travel. | | | | | | | | | | | | | | 🞏 |
| **Referrer Name Printed:** | | | | | | **Referrer Signature:** | | | | | | | | |
| **Designation Printed:** | | | | | | **Date and Time of referral:** | | | | | | | | |
| **Podiatry Service Use Only** | | | | | | | | | | | | | | |
| **Date referral Received by PRMC:** | | | | | | | | | | | | | | |
| **Referral Triage Decision** | | | | | **Action** | | | | | | | | | |
| 🞏 | Accept referral | | | | Staff triaging complete Referral Priority and Stream boxes below. PRMC to process referral accordingly | | | | | | | | | |
| 🞏 | Return insufficient information | | | | PRMC to return to referrer with request for further information, using standard cover lever | | | | | | | | | |
| 🞏 | Reject not eligible | | | | PRMC to send standard response letter to referrer and patient using standard letter | | | | | | | | | |
| 🞏 | Specialist Triage | | | | Requires appropriate clinician to review- PRMC to arrange | | | | | | | | | |
| 🞏 | Forward to another Service | | | | Diabetes MDT 🞏 | | | | | Orthotic Services 🞏 | | | | |
| Other 🞏- State: | | | | | | | | | |
| **Referral Priority:** | | | 🞏 Urgent | | 🞏 Routine Priority (B7 MSK only) | | | | | | | 🞏 Routine | | |
| **Referral Stream:** | | | 🞏  Doms | | 🞏  General | 🞏  DSP | | | 🞏  Gen. MSK | | | 🞏  Spec. MSK | 🞏  Paeds | |
| **Date & Time:** | | | | | **Name & Designation:** | | | | | | | **Signature:** | | |