**Domiciliary Podiatry Referral form**

**for Use by GPs and Health Care Professionals**

Please send this form as an attachment to [t-sd.dompodappts@nhs.net](mailto:t-sd.dompodappts@nhs.net)

|  |  |
| --- | --- |
| Patient Name: |  |
| NHS/ICS Number: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer and contact details: |  | Date Received: |  |

|  |  |
| --- | --- |
| **Is a foot pressure ulcer present?** | YES/NO |
| **If yes has a Datix form been completed?**  *If no, please complete in line with Trust policy* | YES/NO |
| Datix Incident Number |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **If diabetic, result of foot Assessment:** | | | | | |
| Low risk |  | High risk |  | At risk |  |
| Ulcerated Foot |  | Level of pain 0-10 |  | | |
| Open Wound |  | Infection |  | | |

Please carefully select the level of urgency *- please x appropriate timescale*

|  |  |
| --- | --- |
| **Urgent – follow up required within 24/72 hours** (*recent amputation, infection/ulceration)* |  |
| **Priority – 10 working days** (*severe pain, infection/ulceration)* |  |
| **At Risk** (*patient to be seen 0-6 weeks)* |  |
| **Routine – 8 weeks** (*next available routine appt)* |  |

|  |  |  |
| --- | --- | --- |
| Medical/Surgical history: | | |
| Antibiotic therapy | Yes/No | Medication: |

|  |  |  |
| --- | --- | --- |
|  | Yes/No | Additional Information |
| Does the individual have any sensory impairment? | Yes/No |  |
| Does the individual use recreational drugs/alcohol and does this pose a threat? | Yes/No |  |
| Has the individual been diagnosed with mental health/personality disorders, learning disabilities or are there any adult protection concerns? | Yes/No |  |
| Does the individual have any history of violence/abuse/bullying/domestic violence? |  |  |

**Guidelines**

* If a patient is able to leave their home for **any** reason, either assisted or unassisted for visits such as Doctors, Hospital appointments, shopping, day care, or for social reasons, they are not eligible for a home visit.
* Please send this form as an attachment to [t-sd.dompodappts@nhs.net](mailto:t-sd.dompodappts@nhs.net)
* Incomplete Referral forms may cause a delay in the processing of the application and could potentially cause a further delay in the timescale when the patient is seen.