Whittington Health NHS

PODIATRY SELF-REFERRAL FORM

PLEASE NOTE: GP must be in ISLINGTON area.

Please complete this form in as much detail as possible and **post OR email** to:

Post:
Central Booking Service (CBS)
Level 4, Highgate Wing
Dartmouth Park Hill
London N19 5JG

Email: arti.centralbooking@nhs.net

NHS NUMBER (if known):		Today's Date:
Title: Mr/Mrs/Miss/Ms	First Name:	Surname:
Address:		DOB:
		Postcode:
Home Phone no:	Work phone no:	Mobile Phone no:
GP name and Practice:		
First Language	Ethnicity	
Do you require an interpreter? Yes ☐ No ☐		
Are you house bound? Yes ☐ No ☐		
Please give a brief description of why you need a foot assessment:		
How long have you had this complaint? Days ☐ Weeks ☐ Months ☐ Years ☐		

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Are the symptoms worsening? Yes ☐ No ☐

Are you off work or unable to care for dependant because of this problem?

Yes ☐ No ☐ Not Applicable ☐

GENERAL HEALTH

Please tick if you have any of the following:

Diabetes	☐	Stroke	☐
Poor circulation	☐	Heart disease	☐
Rheumatoid arthritis	☐	Eczema/psoriasis	☐
Foot/Leg amputation	☐	Foot/Leg ulcers	☐

MEDICATIONS

Please list all medications/tablets you are taking:

FOOT HEALTH

Please tick if you suffer from any of the following:

Infection or ulcer	☐	Heel Pain	☐
Ingrowing toenail	☐	Pain on walking	☐
Painful corns	☐	Verrucae	☐
Thickened nails	☐	Joint pain in feet	☐