NHS Western Isles Podiatry Service

If you have email access, please return forms to wi.podiatry@nhs.scot including photographs where possible.

Why are you referring yourself to Podiatry?

Name:		**M** ☐ **F** ☐	**Date of Birth:**		
Address:			**Home**		
			Mobile		
			Work		
Post Code		**e-mail**			
GP Practice			**Tel No.**		
Does client have:	Power of attorney ☐ Guardianship ☐ N/A ☐				

(Please circle YES in the appropriate box)

I have a foot ulcer	A wound to your foot which may be discharging fluid. Surrounding skin will look normal (Please note: If infected, surrounding skin may be red, hot, swollen, painful; you may also need to contact your GP)	YES
I am concerned about the circulation in my leg(s)	One, or both legs have recently, or suddenly, become cold, changed colour or become very painful	YES
I am in intense pain	My foot pain is so bad that I cannot walk properly	YES
I have an ingrown toenail	My nail has pierced the flesh and there is discharge from the wound (Please note: If infected, surrounding skin may be red, hot, swollen, painful; you may also need to contact your GP)	YES
I am in pain	You have daily foot or ankle pain which is annoying but not disabling	YES
One or more nails is not manageable	Some of your nails may be extremely thick, painful, misshapen or neglected	YES
I have a painful corn	You have an area of callus on your foot which is causing discomfort	YES
Other	Please give details if your problem is not described above:	

How long have you had this problem?

Less than 2 wks ☐ 2-12 weeks ☐ 3-12 months ☐ Over 1 year ☐

Please note incomplete forms will be returned which may result in a delay issuing an appointment.

What medical conditions do you have?	**(Just write NONE if you have no medical conditions)**
What daily medication do you take?	**(Just write NONE if you do not take regular medication)**
What allergies do you have?	**(Just write NONE if you do not have any allergies)**

Appointment Support:	If you require communication support please specify below
Language Line ☐	**None required** ☐

Emergency Contact:			
Name		**Tel. no.**	

Name of referrer:	**Date:**
Relationship if completing on behalf of patient:	

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