(Office use only) CHI No. ..... Date received ..... Clinic.....

MORAY PODIATRY SERVICE SELF REFERRAL FORM

Please complete all sections in BLOCK CAPITALS (incomplete forms will be returned)

Please note we DO NOT CARRY OUT SIMPLE NAIL CUTTING

Your first appointment may be for assessment only and treatment **may not** be given at that time

Your first appointment maybe via telephone

If appropriate you may be offered a virtual consultation using `Near Me`

Title		Surname	
First Name(s)			
Address			
Post code		Date of Birth	/ /
Home Tel		Mobile	
Email address			
Next of Kin	Name		Tel
Name of GP practice			

Do you speak and understand English ? (please circle) **YES** **NO**

Do you have any difficulty (please circle) **Seeing Understanding Hearing Communicating**

Please give brief details

Do you use **a wheelchair** **aid or stick** **walk independently** **need to be accompanied**

(please circle)

Do you have help to wash and dress or other care need ? (please circle) **YES** **NO**

Who helps you ?

Name of Care Company (if you have one)

Height ..... cms/ins Weight..... Kgs/Stones

What style of footwear do you wear most of the time (please circle)

Slip on **Laced** **Velcro fastened** **Strap** **Prescribed** **Other** .....

Do you have any medical conditions? Have you had any surgery? (please circle) NO YES (please list below)

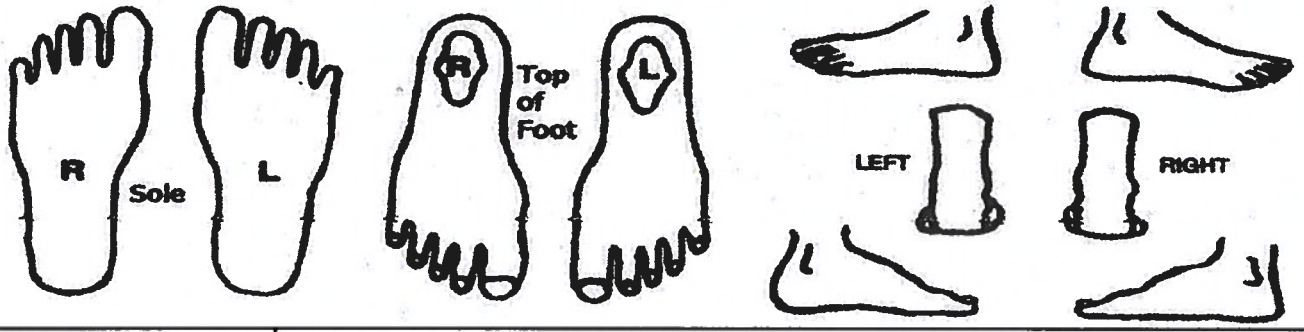
List Out Patient Clinics you attend

Please list any **Allergies**

Do you have ? _ Hepatitis B Hepatitis C HIV CJD None of these (please circle)

Please list below **All** your current medication (include `over the counter` and herbal medicines that you take regularly)

Please mark on diagrams below where your current foot problem is (please use circle or X)



Is the area? (please circle)	RED SWOLLEN PAINFUL DISCHARGING (pus/fluid) BLEEDING OPEN DISCOLOURED
Does the problem stop you or severely impact on your..... (please circle)	Sleeping walking working sports activities none of these
	All of the time Some of the time Never
How painful is it? (please circle)	No pain 0 1 2 3 4 5 6 7 8 9 10 Terrible

Briefly describe your current foot problem, how long you have had it and what you have done to help it

Have you seen anyone else about this problem? Please give details and approximate dates			
Please Sign (please state relationship if signing on behalf of applicant)		date	

Please return COMPLETED form to -
Podiatry Department, The Glassgreen Centre, 2 Thornhill Drive, Elgin IV30 6GQ

or email to gram.moraypodiatry@nhs.scot

(You may attach a photo of your foot problem to your application)