

**PODIATRY SERVICES REFERRAL FORM – VALE OF YORK LOCALITY**

|  |  |  |  |
| --- | --- | --- | --- |
| NHS Number |  | Referrer Details / Registered GP Practice |  |
|  |  |
| Date of Birth | Male/Female |
| Surname | Forename (s) | Date of referral ……………………………………………………………………. |
| Referral to ***ONLY TICK ONE BOX PER FORM*** |
| Address |
| Community Podiatry |  | Nail Surgery |  |
| Podiatry Wound Care |  | Biomechanics |  |
| MDT Foot Clinic |  |  |  |
|  |  |  |  |
| Day Time Telephone No |  | Preferred location for treatment: |
| Mobile |  | Can short notice appointments be taken? YES / NO |
| Other Contact |  | **ANY KNOWN RISKS** |
| **Reason for referral** | **Medical History and Medication** |
|  | Consented to shared records on SystmOne Print out attachedReferrer’s signature ……………………………………Print Referrer’s name ……………………………………….. Date of referral……………………………………… |
| Referral priority | FOR OFFICESpecify Podiatrist if appropriate | USE ONLYDate referral received ………………………………………………………………….. |
| Emergency |  |  |
| Urgent |  |  |  |  |  |
| Soon |  |  |  |  |  |
| Waiting list |  |  |  |  |  |

Fax Completed Form to – 01423 542310

Or Email Form to - hdft.swrpodiatryreferrals@nhs.net Post to: Podiatry Services, White

Tel No: 01423 542300

Cross Court, White Cross Gardens,

Ramsay Clsoe, York ,YO31 8FT