

**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 attached  Referrer’s signature ……………………………………  Print Referrer’s name ……………………………………….. Date of referral……………………………………… | | | | | |
| Referral priority | | FOR OFFICE  Specify Podiatrist if appropriate | | USE ONLY  Date referral received ………………………………………………………………….. | | | | | |
| Emergency |  |  | |
| Urgent |  |  | |  |  | |  | | |
| Soon |  |  | |  |  | |  | | |
| Waiting list |  |  | |  |  | |  | | |

Fax Completed Form to – 01423 542310

Or Email Form to - [hdft.swrpodiatryreferrals@nhs.net](mailto:hdft.swrpodiatryreferrals@nhs.net) Post to: Podiatry Services, White

Tel No: 01423 542300

Cross Court, White Cross Gardens,

Ramsay Clsoe, York ,YO31 8FT