|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | | | | | | | | | | **NHS Number:** | | | | | | | | |
| **Address:** | | | | | | | | | | | | **Date of Birth:** | | | | | | | | |
| **Gender** | | |  | | | | | |
|  |  | | | | | | | | | | | **Is the patient a military veteran?** | | | **Y** | | | **N** | | |
| **Tel No:** |  | | | | | | | | | | | **Does the patient have a registered carer?** | | | **Y** | | | **N** | | |
| **Mobile:** |  | | | | | | | | | | | **Email Address:** |  | | | | | | | |
| **The service will be providing telephone and video consultations as part of patient care.  We need to  know if you have access to any of the following:** | | | | | | | | | | | | **If you are able to send images of the injury/issue please attach to this referral or send to:** [snhs.podiatrypatientimages@nhs.net](mailto:snhs.podiatrypatientimages@nhs.net) | | | | | | | | |
| **Smartphone** | **Y** | | | | | | | | **N** | | |
| **Tablet** | **Y** | | | | | | | | **N** | | |
| **Laptop / Desktop PC** | **Y** | | | | | | | | **N** | | |
| **Does the device have a camera and sound?** | **Y** | | | | | | | | **N** | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **GP:** | | | | | | | | | | | | **Practice Address:** | | | | | | | | |
| **Tel No:** |  | | | | | | | | | | |
| **Safeguarding** | **Reported Yes/No** | | | | | | | | | | | **Link if Known:** | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Medical History Summary:** | | | | | | | | | | | | | | | | | | | | |
| **Diabetes** | | **Y** | | **N** | | **If yes: Complete Diabetes Foot Assessment** [**(DFA)**](http://www.portsmouthdiabetes.co.uk/admin/resources/uploaded/Diabetic%20Foot%20Assessment392.pdf) **Form must be attached** | | | | | | | | | | | | | | |
| **Current Medication:** | | | | | | | | | | | | | | | | | | | | |
| **Reason for Referral:**  **Please describe the problem in detail to allow accurate triage:**  **Please provide as much detail as possible** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Current Foot Ulceration?** | | | **Y** | | | | **N** | | | **If Yes: please follow Diabetic Foot Referral Pathway** | | | | | | | | | | |
| **Description of ulcer:**  **Location, size, depth, wound bed description, duration, presence of neuropathy, ischemia, previous amputation** | | | | | | | | | | | | | | | | | | | | |
| **Current Antibiotic Regime: Name, dose duration date commenced** | | | | | | | | | | | | | | **History of MRSA** | | **Y** | | | | **N** |
| **In growing toenail?** | | | | | **Y** | | | **N** | | | **If yes please state if Antibiotics have been prescribed** | | | | | | **Y** | | **N** | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Details of referrer** | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | | | | | **Correspondence Address:** | | | | | | | | | |
| **Designation:** | | | | | | | | | | |
| **Signed:** | | | | | | | | | | |
| **Date:** | | | | | | | | | | | **NHS.net address:** | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |

**Diabetes Foot Assessment (DFA)**

**For use in conjunction with the Podiatry Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | | | | Assessment Date: | | | | | | | | | | |
| Address:  Post Code: | | | | | | | Date of Birth: | | | | | | | | | | |
| NHS No: | | | | | | | | | | |
| GP: | Surgery Name: | | | | | | Green  Low Risk | | | | Amber  Moderate Risk | | | Red  High Risk | | | |
| *Does the patient has any one of these?* | | | | | | |  | | | |  | |  | | | |  |
| Neuropathic, red, hot, swollen foot – suspected acute Charcot? | | | | | | | URGENT Refer to Diabetes Foot MDT per Pathway | | | | | | | | | | |
| Active foot ulceration | | | | | | |
| Critical limb ischemia (cold, pulseless, painful foot) | | | | | | | Urgent refer to Vascular or ADMIT to SAU | | | | | | | | | | |
| Gangrene (New presentation) | | | | | | |
| Spreading infection and systemically unwell | | | | | | |
| Does the patient have? | | | | | |  | | No | | | Yes | | | | | | |
| A previous amputation? | | | | | |  | | Green | |  | | RED | | | |  | |
| Past history of foot ulcer? (below the ankle) | | | | | |  | | Green | |  | | RED | | | |  | |
| Asymptomatic absent foot pulses? Both foot pulses in one or both *feet* | | | | | |  | | Green | |  | | RED | | | |  | |
| Symptomatic absent foot pulses? (*intermittent claudication/rest pain/ previous vascular surgery – NB NOT NEUROPATHIC PAIN)* | | | | | |  | | Green | |  | | RED | | | |  | |
| Less than 8 of 10 sites with 10g monofilament? Either foot | | | | | |  | | Green | |  | | Amber | | | |  | |
| On renal replacement therapy | | | | | |  | | Green | |  | | RED | | | |  | |
| Previous Charcot foot ( not active and no ulceration ) | | | | | |  | | Green | |  | | Amber | | |  | | |
| Significant foot deformity | | | | | |  | | Green | |  | | Amber | | |  | | |
| Glycaemic control HbA1c | | |  |  |  |  | | |  | | | | | | | | |
| If the patient has any ticks in the YES column they will be either Moderate or High Risk depending on the RAG rating of the box. RED = HIGH RISK. AMBER = MODERATE RISK  Please refer to Podiatry giving full details on the Podiatry referral form and include this form. | | | | | | | | | | | | | | | | | |
| If the patient has **only green** squares ticked they are Low Foot Risk. Please **do not refer to Podiatry** but provide them with the following essential information: | | | | | | | | | | | | | | | | | |
| * Basic foot care advice and the importance of foot care. * Foot emergencies and who to contact. * Footwear advice. * The person's current individual risk of developing a foot problem. * Information about diabetes and the importance of blood glucose control * Alternative ways of accessing Private Podiatry – Tip Toe 0300 300 2015 or Private Podiatry HCPC registered. | | | | | | | | | | | | | | | | | |
| Is the patient happy to be referred? YES  NO | |  | | | | | | | | | | | | | | | |
| Assessors Name: Role: | |  | | | | | | | | | | | | | | | |

**Any incomplete or inappropriate referral forms will be sent back to the referrer which may result in delayed treatment**

|  |
| --- |
| **If Using SystmOne:** Please send this form via electronic referral selecting the followingtask recipient  1 New Podiatry eReferral |
| **If Not Using SystmOne:** Please send this form to**:** [SNHS.solentnhspodiatry@nhs.net](mailto:SNHS.solentnhspodiatry@nhs.net) |
| **For Further Advice, Contact Us On**: Tel No: 0300 300 2011  Podiatry Service, 1st Floor, Adelaide Health Centre, William Macleod Way, Millbrook, SO16 4XE |