South Eastern Health and Social Care Trust

PODIATRY SELF REFERRAL FORM

In order to assess your need for Podiatry treatment, please give as much information as possible. Thank you.

Surname:	Date of Birth:
Forename(s):	GP Name:
Address: Postcode:	GP Address: Postcode:
Contact Telephone Numbers: Home: Work: Mobile:	

REASON FOR REQUESTING PODIATRY TREATMENT

Arch Pain	☐	Bunion Pain	☐	Corn	☐
Difficulty cutting nails	☐	Hard Skin	☐	Heel Pain	☐
Ingrowing Toenails	☐	Verucca	☐	Other, please state	

MEDICAL CONDITIONS (AS DIAGNOSED BY YOUR G.P.)

Alzheimers/Dementia	☐	Circulatory Disease	☐	Diabetes	☐
Renal Disease	☐	Learning Disability	☐	Osteoarthritis	☐
Multiple Sclerosis	☐	Parkinsons Disease	☐	Registered Blind	☐
Rheumatoid Arthritis	☐	Stroke	☐	Other, please state	☐

CURRENT MEDICATION

Anti Coagulants (Warfarin)/(Plavix) ☐ Steroids ☐ Other, please state or attach list:

____

Have you been prescribed a course of antibiotics for your foot problems in the past month?

Yes ☐ No ☐

Signature________________________________ Date____________

Please complete the above sections and return this form to:

PODIATRY DEPARTMENT
BANGOR COMMUNITY HOSPITAL
CASTLE STREET
BANGOR, CO. DOWN
BT20 4TA

Official Use		
Application Received	Category: E / U / Non urgent (Clinic)	Non Urgent (Health Education)
Referral Code	Location of Assessment	

PT12915