NHS Western Isles Podiatry Service DOES NOT carry out SIMPLE nail cutting

Please return completed electronic forms to: podiatrywi@nhs.net
(please mark e-mail "new referral")

Or Post: Podiatry Department, Western Isles Hospital, Macaulay Road, Stornoway, HS1 2AF

Personal Information				
Name:		**M** ☐ **F** ☐	**Date of Birth:**	
Address:		**Please place 'X' in box to indicate your preferred contact method**	**Home**	
			Mobile	
			Work	
Post Code		**e-mail**		
GP Practice			**Tel No.**	
Does client have:	Power of attorney ☐ Guardianship ☐ N/A ☐			

What is your main reason for referring yourself to the service?	
Is the problem area: **red** ☐ **swollen** ☐ **bleeding/ discharging/weeping** ☐	
Please note: Patients with Diabetes If you have been seen by Podiatry in the past please contact the department directly.	**Diabetes**: Yes ☐ No ☐

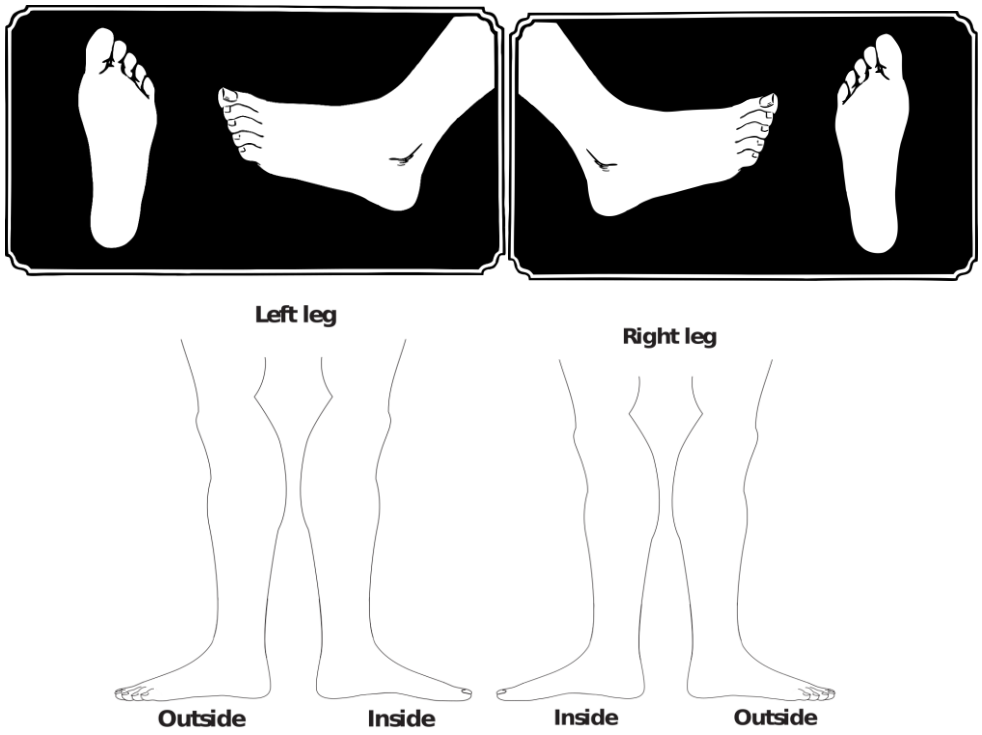
How long have you had this problem?

2wks ☐ 2-12 weeks ☐ 3-12 weeks ☐ Over 1 year ☐

Is the problem causing pain?	Yes ☐ No ☐
Is the problem preventing you from attending work / school?	Yes ☐ No ☐
Are you self employed or work for a small company (fewer than 250 people)?	Yes ☐ No ☐
Do you exercise for 20 minutes daily	Yes ☐ No ☐
Have you had treatment for this problem before? If Yes please state where and by whom.	Yes ☐ No ☐

Please complete other side

Use the diagrams to help identify where your main reason for referral is by using an (x).



Please list all other medical conditions	
If **NONE** *please tick this box* ☐	
Please list all CURRENT MEDICATIONS ***(attach a prescription tear-off slip if possible)***	
If **NONE** *please tick this box* ☐	
Allergies?	Yes ☐ *specify*

Appointment Support:	If you require communication support please specify below
Language Line ☐ **None required** ☐	
Do you have a physical disability?	Yes ☐ No ☐ Wheelchair User ☐

Emergency Contact			
Name		**Tel. no.**	

Print name:	**Date:**
Relationship if completing on behalf of patient:	

Please note incomplete forms will be returned which may result in a delay issuing an appointment.