Podiatry and Foot Protection Service - Professional Referral Form *(Version 5 Mar 24)*

South West Yorkshire Partnership NHS Foundation Trust

Date of referral……

Please complete all sections of the form marked with an asterisk (*) or the form will not be processed and returned to the referrer.
PLEASE NOTE THE PODIATRY DEPARTMENT DO NOT OFFER A NAIL CUTTING SERVICE

*PATIENT DETAILS	Address:
Name:	
D.O.B:	Post Code:
NHS Number:	Tel. No.:
Next of Kin / Carer (including contact details):	*Please ensure the telephone number listed is the most recent accurate number for the patient.*
Registered GP Practice:	

REFERRED BY

Name: **Designation:** **Tel. No.:**

EXCLUSION CRITERIA

- **Nail Care – including fungal nail infections.**
- **Verrucae.**
- **Non-symptomatic corns/callous.**
- **Dry skin conditions such as Eczema/Psoriasis.**
- **Non painful biomechanical problems.**

INCLUSION CRITERIA** ***(please tick the reason for referral, failure to specify will result in the referral being rejected):

- ☐ **Recurrent ingrown toenail(s) requiring surgical intervention.**
- ☐ **Active foot wound.**
- ☐ **Painful corns/callous with high-risk medical conditions.**
- ☐ **Pain because of a suspected biomechanical pathology.**
- ☐ **Group Education Session for Neuropathy.**

REFERRAL FOR ***(Please tick the service element required):***

Wound Care ☐ Biomechanical Assessment ☐ High Risk Foot Assessment ☐ Nail Surgery ☐

(a photograph must be attached, and the patient should be aware that they are being referred for a surgical assessment)

REASON FOR REFERRAL	*Pain Level (*for Biomechanical referrals only*):
*Please give as much detail as possible:	Low ☐ Medium ☐ High ☐
	Provide details of self-care that has been attempted prior to the patient being referred?
Please specify if the patient has previously accessed the Barnsley Community Podiatry Service:	

***MEDICAL HISTORY**

ADDITIONAL INFORMATION

Interpreter / Signer Required: Yes ☐ No ☐ Language:

E-mail completed referrals to: rightcarebarnsleyintegratedspa@swyt.nhs.uk