|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | | | | | | | | | **NHS Number:** | | | | | | |
| **Address:** | | | | | | | | | | | **Date of Birth:** | | | | | | |
| **Gender** | | | |  | | |
|  | **Post Code** | | | | | | | | | | **Is the patient a Military Veteran?** | | | | **Y** | **N** | |
| **Tel No:** | **Mobile:** | | | | | | | | | | **Does the patient have a Registered Carer?** | | | | **Y** | **N** | |
|  | | | | | | | | | | | | | | | | | |
| **GP:** | | | | | | | | | | | | **Practice Address:** | | | | | |
| **Tel No:** | **Fax 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, ischaemia, previous amputation** | | | | | | | | | | | | | | | | | |
| **Current Antibiotic Regime: Name, dose duration date commenced** | | | | | | | | | | | | | **History of MRSA** | **Y** | | | **N** |
|  | | | | | | | | | | | | | | | | | |
| **Ingrowing Toenail?** | | | | **Y** | | | **N** | | | **If Yes: Please State if Antibiotics Have Been Prescribed** | | | | | **Y** | **N** | |
| **Foot Pain?** | | | | **Y** | | | **N** | | | **Mild Pain**  **Moderate Pain**  **Severe Pain** | | | | |  |  | |
| **Please Describe the Problem**  **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 have 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 ischaemia (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 bothfeet | | | | |  | 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: GREEN = LOW 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 03003002015 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 URGENT referrals please fax to 02380 784 009** |
| **For Further Advice, Contact Us On:** Tel No: 0300 300 2011  Podiatry Service, 1st Floor, Adelaide Health Centre, William Macleod Way, Millbrook, SO16 4XE |