NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Wrightington Wigan & Leigh Podiatry Service Referral Form

(IF NOT BEING COMPLETED BY THE PATIENT):

NAME OF REFERRING AGENT:	Date:
CONTACT DETAILS:	

PLEASE COMPLETE ALL FIELDS - INCOMPLETE FORMS WILL BE RETURNED

Title		First Name(s)			Known as (or preferred name if different)		
Family Name / Surname					Is English your first language? Do you need an interpreter?		
Date of Birth				NHS Number			
Home Address (including post code)							
Tel No (including code)				Mobile No			
Name of Registered Doctor				Surgery Address			
Emergency Contact				Relationship			
Tel No (including code)		Mobile No		Work No			

ABOUT YOUR HEALTH AND FOOT PROBLEM – To be completed by the Patient / Referrer

Do any of the following conditions apply, please delete as appropriate: Heart Disease YES/NO Poor circulation YES/NO Biomechanical problem (*To be completed by a healthcare professional only*)	Diabetes Increased/High risk diabetic as per Primary care Pathway (*To be ticked by a healthcare professional only*)	YES / NO YES / NO
	Rheumatoid Arthritis	YES / NO
	Loss of sensation in feet	YES / NO
It is essential that a copy of your medication is included. Have you attached a copy of your prescription or a list? ☐ Yes ☐ I do not take any prescribed medication	Please give a brief description of the foot problem	
Please state any allergies:		

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Please give any other information which you feel is relevant (include here details of any injuries sustained during Military service)

ETHNIC MONITORING

To help us ensure that the service we provide unbiased and equally accessible to everyone, we are required to record the ethnicity of the people that use our service. This information will be treated with confidentiality.
Please look at the following list and tick the ethic group to which you belong.
Please ✓ as appropriate

A	☐	**White British**	**K**	☐	**Bangladeshi**
B	☐	**White Irish**	**L**	☐	**Any Other Asian Background**
C	☐	**Any Other White Background**	**M**	☐	**Black Caribbean**
D	☐	**White and Black Caribbean**	**N**	☐	**Black African**
E	☐	**White and Black African**	**P1**	☐	**Black British**
F	☐	**White and Asian**	**P2**	☐	**Any Other Black Background**
G	☐	**Any Other Mixed Background**	**R**	☐	**Chinese**
H	☐	**Indian**	**S**	☐	**Any Other Ethnic Group**
J	☐	**Pakistani**		☐	**Prefer not to say**

Following receipt of this referral form, you may be asked to attend an appointment for an assessment carried out by a podiatrist, if you meet criteria. All assessments will be carried out at a clinical location.

Please return this form to:

Podiatry Administration,
ICS Hub
Golborne Clinic
Lowton Road
Golborne
WA3 3EG

Tel: 0300 707 7700

E.Mail: wwl-tr.podadmin1@nhs.net

THIS SECTION IS FOR ADMIN USE ONLY

Date Received	Urgent / Soon / Routine	Preferred Clinic	Checked by Podiatrist (Name)	Date