# Confidential Application for Podiatry Treatment

Please complete all details marked with \* and email to: podiatry@northampton.ac.uk

An appointment will then be sent to you.

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| Clinic Stamp:(Office use only) | Date form received:Appt Date: Time:(Office use only) |
| Patient details |
| \*Mr/Mrs/Ms/Child/Other (please circle) | \*Name: | \*Surname: |
| \*Address      \*Postcode:      \*Email address:        Would you like correspondance sent by post or email?     Post/Email     |
| \*Date of Birth:  | \*Contact Number: | \*Mobile Number: |
| \*Emergency contact |
| \*Mr/Mrs/Ms/Child/Other (please circle) | \*Name: | \*Surname: |
| \*Address     \*Postcode:       |
| \*Contact Number: | \*Mobile Number: |  |
| \*Doctors details |
| \*GP Name: |  |
| \*Surgery Address:      Postcode:       Contact Number:       |
| \*Podiatry/Chiropody Problem |
| \*Where on your foot does it hurt/cause a problem? (e.g. Pain in heel of the right foot)  |
|  |
| \*Mark with an X where on the foot it hurts |
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| \*Details and medical history of your foot problem: |
| \*How long have you had this problem? (Days/Weeks/Years?): |
| \*Is your problem painful? Yes / No | If Yes, is it: Mild / Moderate / Severe |  |
| \*Are there any signs of: Redness / Weeping / Swelling / Heat / Bleeding / None |
| \*Have you received any medical treatment for this problem? Yes / NoIf Yes, Please give details |
| \*Are you currently taking any medication? Yes / NoIf yes, please list all tablets and medicine that you take (check your repeat prescription)\*Do you have any known allergies? Yes / No (e.g. Penicillin, latex, local anaesthetics, car/dog hair, hay fever etc) |
| \*Have you seen a Podiatrist or Chiropodist in the last 2 years? Yes / NoIf Yes, Where did you receive this treatment? |
| All treatment is based on medical needs:\*Do you have or have you suffered from any of the following: |
|  |
| Condition | Yes / No | Condition | Yes / No |
| Diabetes |  | Registered blind or partially sighted |  |
| Circulation problems (e.g. Raynaud’s) |  | Special educational needs |  |
| Immunosuppression(e.g. Renal problems) |  | Congenital problems |  |
| Rheumatoid Arthritis |  | Neurological e.g. Multiple Sclerosis |  |
| Osteoarthritis |  | Terminal Illness |  |
| Stroke |  | Dementia |  |
| Heart problems |  | \*Other ailments not listed (state below) |  |
| A person with physical disabilities |  |  |  |
|  |  |  |  |
| Ethnic Origin - please circle: |
| A – White British | G – Mixed – Any other mixed background | N – Black/Black British African |
| B – White Irish | H – Asian Indian | P – Any other Black Background not stated |
| C – White – Any other not stated | J – Asian Pakistani | R – Chinese |
| D – Mixed – White and Black Caribbean | K – Asian Bangladeshi | S – Other ethnic groups not stated |
| E – Mixed – White and Black African | L – Any other Asian not stated | Z – Prefer not to state |
| F – Mixed White and Asian | M – Black/Black British Caribbean  |  |
|  |  |
| \*Personal Situation |
| \*Who currently cares for your feet? Self / Relative / Partner / Other (please specify) |
| If this has changed please explain why |
| \*Consent of Treatment |
| I consent to treatment, confirm the information given above is correct and agree to pay due charges for consumables.Signature of applicant:..................................................................... Date: ..............................................Children under 16years old require a signature from their parent or legal guardian:Signature on behalf of child:............................................................. Date: ..............................................Mother/Father/Guardian/ |
| Practitioner Notes (Office use only) |
| Clinic referred to: Monday Orthopaedic Podiatric medicine Tuesday General At Risk Wednesday Injection therapies Thursday Routine Friday Sports Paediatric  |

The University of Northampton’s Podiatry Clinic, School of Health, Cliftonville Road, Northampton, NN1 5BF – 01604 893232