Bromley Healthcare
better together

FOOT HEALTH SERVICE
PODIATRY APPLICATION FORM

It is important to complete all sections in full. Please telephone and ask if you do not understand any part. **01689 866502 or 01689 866607. Fax: 01689 866520**
Incomplete forms will be returned

Today's Date _____ Date received (office use only):_____

A) PATIENT DETAILS

Mr/Mrs/Miss/Ms/Other: SURNAME: FORENAME:	DATE OF BIRTH
ADDRESS: POSTCODE:	
TELEPHONE No. Home: Work: Mobile: Can we text you? Yes ☐ No ☐	
Gender Male ☐ Female ☐	NHS NUMBER:
Emergency contact Name: Relationship to patient: Contact number:	
If an interpreter is needed what language is spoken?	
WHEELCHAIR USERS You will be required to transfer from your chair to the examination couch. If you require assistance with this please attend with someone who can help. Please note that hoists and lifting devices are not available within our clinics.	

B) GENERAL PRACTITIONER

GP NAME:
ADDRESS:

REFERRAL DETAILS (Please complete this section, if you are referring somebody other than yourself)

NAME:
PROFESSION:
DEPARTMENT/ORGANISATION:
ADDRESS: E-MAIL:
TELEPHONE: EXTENSION:

Do you have a long-standing disability, illness or infirmity that limits your day-to-day activities?

Yes ☐ **No** ☐

If Yes, what is the nature of your disability? (e.g wheelchair user, visual or hearing impairment etc)

C)

Are you housebound? Yes ☐ No ☐ (If 'No' go to Section D)

Please state your medical/physical reasons for being housebound/chair-bound.

(NB: If left blank, a clinic appointment will be offered)

Are you able to open your front door? Yes ☐ No ☐

Do you attend a day centre? If **'Yes',** please state name of day centre and days you attend.

D) FOOT PROBLEMS

Please give **precise details** of your foot problems(s):
If this section is left blank the form will be returned to the patient/sender.

E) GENERAL HEALTH DETAILS

Please indicate with a tick √

Do you have any medical problems? : Yes ☐ No ☐
If yes, do you have any of the following problems:

Diabetes	☐	**Heart / Circulation**	☐
Rheumatoid Illness	☐	**Chest / breathing**	☐
Blood / Bleeding	☐	**Liver problems**	☐
Kidney problems	☐	**Cancer**	☐

Any other health problems not mentioned above?

F) MEDICATION

Please indicate with a tick √

Do you currently take any medication,
Including tablets, creams, inhalers or injections? Yes ☐ No ☐

If **'Yes'** please give details below

To help ensure we provide an equitable service to all the residents of Bromley, please complete this section

What is your ethnic group? (please tick)

	White:		Black or Black British:
A	☐ British	M	☐ Caribbean
B	☐ Irish	N	☐ African
C	☐ Any other White background	O	☐ Any other Black background
	Mixed:		Asian or Asian British:
D	☐ White and black Caribbean	H	☐ Indian
E	☐ White and Black African	J	☐ Pakistani
F	☐ White and Asian	K	☐ Bangladeshi
G	☐ Any other Mixed background	L	☐ Any other Asian background
	Chinese or other ethnic background:		
R	☐ Chinese		
S	☐ Any other ethnic group		

Who is completing this form?

Patient ☐ **GP surgery** ☐ **Relative** ☐ **Carer** ☐ **Other please state**

Name of person completing form (please print)

Date