

# REFERRAL TO PODIATRY – WEST LOCALITY

**Please complete *all* sections of this form**

### Patient's Details

Title:		Forenames:		Surname:	
Date of Birth:			NHS Number:		
Address:				Telephone:	
				Mobile Phone:	
				Ethnic Origin:	

### Patient's Next of Kin

Name:		Telephone:	
Relationship to Patient:			

### Application

Any Recent NHS Podiatry Treatment Received?		Yes		No	Totally Housebound? <i>(GP referral and signature required for home visit)</i>		Yes	<i>GP's Signature</i>		No
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**Reason for Application:**  
*(Requests for nail care will be rejected)*

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**Medical History and Medication:**  
*(Please attach a print-out of any prescribed medication)*

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**Allergies:**

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**Additional Relevant Information:**  
*(e.g. Social factors, disabilities, impaired mobility)*

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Name of GP:		Practice Address:	
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Referral Made By:		Signed:		Date:	
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### Once Completed Please Return to:

Podiatry, Richard Hotham Unit, Bognor Regis War Memorial Hospital, Shripney Road, Bognor Regis, PO22 9PP.

**Phone:** 01243 623654

**Email:** [sc-tr.podiatryreferralswest@nhs.net](mailto:sc-tr.podiatryreferralswest@nhs.net)

**Fax:** 01243 623670