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| **Patient Name:** Click or tap here to enter text. | **NHS no:** Click or tap here to enter text. |
| **St. George’s MRN:** Click or tap here to enter text. | **DOB:** Click or tap here to enter text. |
| **Patient Status:** Choose an item. | **Date of Referral:** Click or tap to enter a date. |
| **Patient Details:**  **Address:** Click or tap here to enter text.  **Postcode:** Click or tap here to enter text.  **Telephone:** Click or tap here to enter text.  **Mobile:** Click or tap here to enter text.  **Email:** Click or tap here to enter text.  Click or tap here to enter text.  **Ethnicity:** Click or tap here to enter text. | **Referrer Details:**  **Name:** Click or tap here to enter text.  **Position:** Click or tap here to enter text.  **Telephone:** Click or tap here to enter text.  **Bleep:** Click or tap here to enter text.  **Email:** Click or tap here to enter text.  **Address/Ward:** Click or tap here to enter text. |
| **Inpatient Details (if applicable):**  **Ward:** Click or tap here to enter text.  **Bay/Bed:** Click or tap here to enter text.  **Admission Date:** Click or tap to enter a date.  **Reason for Admission:** Click or tap here to enter text. | **Is This an Urgent Referral?**  **(To be seen within 1 working day?):** Choose an item.  **If YES, please contact D.F.C on 0208 725 2753 to confirm referral receipt.** |
| **Mobility:** Choose an item. |  |
| **Foot Problem Type**: Choose an item. | **Affected Foot:**  Choose an item. |
| **Referral Reason:** (include duration of current problem and any previous treatments, test results, imaging etc.)  Click **HERE** to enter free text  **Treatment required:** Choose an item.  **Is this a new or recurrent issue?** Choose an item.  **Is this a hospital acquired pressure wound?** Choose an item.  **If YES, has it been reported?** Choose an item. | **Relevant Medical and Surgical History:**  Click **HERE** to enter free text  **Known Allergies:** Click here to enter text.  **History of PVD/Ischaemia:** Choose an item.  **Sensory Neuropathy:** Choose an item.  **Current Smoker:** Choose an item.  **History of Previous Amputation:** Choose an item.  **Mobility:** Choose an item.  **Is Hospital Transport Required?** Choose an item. |
| **Signs of infection?** Choose an item.  **Is the Patient Currently on Antibiotics?** Choose an item.  **If YES, please complete below:**  **Name:** Click or tap here to enter text.  **Dose:** Click or tap here to enter text.  **Duration & Start Date:** Click or tap here to enter text. | **Current Medication:**  Click **HERE** to enter free text |
| **Infection Control Issues (MRSA, C-Dif etc.):** Choose an item.  **If YES, please give details:** Click or tap here to enter text. | Diabetic Foot Clinic  Please note, we do not accept referrals for nail care or routine podiatry / chiropody.  Thomas Addison Unit  St. George’s Hospital  Blackshaw Road  London Email: [stgh-tr.diabeticfootclinic@nhs.net](mailto:stgh-tr.diabeticfootclinic@nhs.net) or  SW17 0QT [Diabetic.FootClinic@stgeorges.nhs.uk](mailto:Diabetic.FootClinic@stgeorges.nhs.uk)  Tel: 0208 725 1429 Fax: 0208 725 0111 |