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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 ClinicPlease note, we do not accept referrals for nail care or routine podiatry / chiropody. Thomas Addison Unit St. George’s HospitalBlackshaw RoadLondon Email: stgh-tr.diabeticfootclinic@nhs.net orSW17 0QT Diabetic.FootClinic@stgeorges.nhs.ukTel: 0208 725 1429 Fax: 0208 725 0111 |