

**DUNDEE
COMMUNITY HEALTH PARTNERSHIP
PODIATRY SERVICE – SELF-REFERRAL FORM**



Dear Patient

Thank you for your enquiry regarding Podiatry Services. In order to register as a patient the following information is required

Please complete in **BLOCK CAPITALS**

Title: Forename Surname

Date of Birth: Height Weight

Address:

Post Code Full Tel No

Previous Address (if within 5 years)

Doctors Name Doctor's Tel

Doctors Address

Please tick which categories apply:

Physical Handicap (which has a direct adverse effect on feet) Diabetes Over 65 years

Mental Illness (In-patient or Social Services client) Chronic Degenerative Neurological Disease Expectant Mother

Nail Surgery Rheumatoid Disease School Child

Other (please specify)

The name, address & telephone number
Of a person we could contact in an emergency

Name of medicines you are currently taking
Which have been prescribed by your doctor

Are you allergic to anything? If yes, give details

Any major leg or foot injuries/surgery?

Medical conditions or problems?

Reason for requesting Podiatry treatment (PLEASE NOTE THIS IS NOT A BASIC NAIL CUTTING SERVICE)
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Please sign and date this form and return to the Podiatry Department, Westgate Health Centre, Charleston Drive, Dundee DD2 4AD.

Patient signature Date

Please note that self-referrals will only be accepted if the patient has the capacity to self-refer, or is being made on behalf of a child. In all other circumstances, referral must be made by a health care professional.