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.