

**DIABETIC FOOT REFERRAL
PROFESSOR M. STEVENS**

PLEASE FAX TO 0121 424 0420

THIS FORM IS FOR BIRMINGHAM HEARTLANDS PATIENTS ONLY

Refer to your nearest A&E Department for URGENT out of hours medical attention

PATIENT DETAILS

NAME:

ADDRESS:

TEL No: NHS No:

DOB: PID:

GP DETAILS

NAME:

ADDRESS:

TEL No:

NAME OF REFERRER **POSITION**

MEDICAL INFORMATION

Diabetes Type 1 Type 2 Cholesterol LDL CHD
HbA1c BP Statin Aspirin

Medication

FOOT RISK ASSESSMENT

Actively Ulcerated	<input type="checkbox"/>	Charcot Joint	<input type="checkbox"/>	Vascular Risk	<input type="checkbox"/>
Foot Deformity/Callous/Fissure	<input type="checkbox"/>	Sensory Neuropathy	<input type="checkbox"/>	Osteomyelitis	<input type="checkbox"/>
Previous Ulcer/Amputation/Orthotics	<input type="checkbox"/>	Gangrene/Necrotic Tissue	<input type="checkbox"/>	Cellulitis	<input type="checkbox"/>
Urgent (next clinic date)	<input type="checkbox"/>	Routine (next available)	<input type="checkbox"/>	Podiatry/ Chiropody Ass	<input type="checkbox"/>

Location of Ulcer

Comments:

OFFICE USE ONLY

Foot Clinic / Podiatry / Chiropody Urgent / Routine

Date Referral Received: Appointment Date: