

FIFE PODIATRY SERVICE

REFERRAL FOR PODIATRY ASSESSMENT



PLEASE RETURN COMPLETED FORM TO: Gate 1, Level 2, Outpatients 3, MSK Hub, Whyteman's Brae Hospital, Whyteman's Brae, Kirkcaldy, KY1 2ND

SURNAME:	TITLE:	DATE OF BIRTH:
FIRST NAME:	CHI NO: (10 DIGIT NUMBER AT THE TOP LEFT OF YOUR PRESCRIPTION)	
ADDRESS:	GP PRACTICE:	
POSTCODE:	PRACTICE ADDRESS:	
CONTACT TEL NUMBER:	PRACTICE TEL NO:	
	MOBILE TEXT REMINDER: YES/NO	
	MOBILE NUMBER:	

PLEASE NOTE THAT NHS PODIATRY DOES NOT PROVIDE A NAIL CUTTING SERVICE

REASON FOR REFERRAL: Please give as much detailed information as possible.	
MEDICAL HISTORY: Please record any health problems you have or have had in the past including allergies.	MEDICATION: Please list all medication/tablets you are taking including any over the counter remedies.
PLEASE SUPPLY ANY OTHER HELPFUL INFORMATION:	
WORK STATUS:	
FIRST LANGUAGE:	DO YOU REQUIRE US TO ORGANISE AN INTERPRETER?

Ethnic Group (please tick box of your appropriate ethnic group)

1A	Scottish	3E	Any mixed or multiple ethnic groups	4D	African, African Scottish or African British	6Z	Other ethnic group
1B	Other British	3F	Pakistani, Pakistani Scottish or Pakistani British	4Y	Other African	98	Refused/Not Provided
1C	Irish	3G	Indian, Indian Scottish or Indian British	5C	Caribbean, Caribbean Scottish or Caribbean British	99	Not Known
1K	Gypsy/ Traveller	3H	Bangladeshi, Bangladeshi Scottish or Bangladeshi British	5D	Black, Black Scottish or Black British		
1L	Polish	3J	Chinese, Chinese Scottish or Chinese British	5Y	Other Caribbean or Black		
1Z	Other white ethnic group	3Z	Other Asian, Asian Scottish or Asian British	6A	Arab, Arab Scottish or Arab British		

REFERRED BY:	DATE:
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