

Rotherham Foundation Trust  
Department of Podiatry  
Self-Referral Form

Surname: _____		Forename(s): _____	
Date of Birth: _____		NHS no: _____	
Address: _____		Postcode: _____	
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GP Name: _____			
Address: _____		Postcode: _____	
Tel no: _____			
Medical Health: (Please tick all that apply)			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Angina	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Attack	_____	
<b>Medication:</b> Please supply a list of <b>ALL</b> tablets, inhalers or creams you are using. You may attach a repeat prescription list if you have one.			
Foot Problem(s):			
Signature: _____		Date: _____	
Please return your completed application form to: Podiatry Department, Rotherham Community Health Centre, Greasborough Road, Rotherham S60 1RY			
PLEASE NOTE: APPLYING FOR NHS PODIATRY DOES NOT NECESSARILY MEAN YOU ARE ELIGIBLE TO RECEIVE TREATMENT			

# Sample Podiatry Referral Forms

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