

Rotherham Foundation Trust  
Department of Podiatry  
Self-Referral Form

|                                                                                                                                                             |                                              |                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------|--|
| Surname: _____                                                                                                                                              |                                              | Forename(s): _____                            |  |
| Date of Birth: _____                                                                                                                                        |                                              | NHS no: _____                                 |  |
| Address: _____                                                                                                                                              |                                              | Postcode: _____                               |  |
| Tel no: _____                                                                                                                                               |                                              |                                               |  |
| 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:<br>Podiatry Department, Rotherham Community Health Centre,<br>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

**R Bogdan**

A red circular graphic with a gradient, appearing as a partial circle or a stylized arrow pointing to the right, located on the right side of the light blue bar.

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