

# FOOT HEALTH SERVICES

## Application Form

**WHO DO WE SEE?** The Foot Health Service team sees anyone who has a foot problem and is registered with a Lewisham GP.

**HOW DO I APPLY?** Please complete this application form and give it, or post it, to the Foot Health Service clinic of your choice. Your application form will then be registered. We will then send you a letter asking you to contact the clinic to arrange an agreed appointment.

**THE FIRST APPOINTMENT** On the day of your agreed appointment you will have your foot problem assessed and advice will be given as appropriate. Not everyone will need treatment, but it will be provided for those who do. Advice about how to manage a foot problem more effectively yourself may be all that is required.

<b>Ladywell Building South Lewisham Hospital</b> Lewisham High St Lewisham SE13 6LH  Tel: 020 3192 6790 Fax: 020 3192 6791	<b>Downham Health &amp; Leisure Centre</b> 7-9 Moorside Road Downham, Bromley BR1 5EP  Tel: 020-3049-1800 Fax: 020-3049-1801	<b>Jenner Health Centre</b> 201 Stanstead Road Forest Hill SE23 1HU  Tel: 020 3049 2446 Fax: 020 3049 2447
<b>Lee Health Centre</b> 2 Handen road SE12 8NP  Tel: 020 3049 2114/2070 Fax: 020 3049 2071	<b>Sydenham Green</b> 26 Holmshaw Close SE26 4TH  Tel: 020 3049 2737 Fax: 020 3049 2701	<b>South Lewisham Health Centre</b> 50 Conisborough Crescent SE6 2SP  Tel: 020 3049 2503 Fax: 020 3049 2501
<b>Waldron Health Centre</b> Stanley Street Deptford SE8 4BC  Tel: 020 3049 3402 Fax: 020 3049 3403	If you are applying for a <b>home visit</b> , please send this completed form to: <b>Lewisham Domiciliary Clerk</b> , Downham Health and Leisure Centre 7-9 Moorside Road BR1 5EP Tel: 020 3049 1860 Fax: 020 3049 1861	

It is important to complete this form in full. Your appointment will depend upon the information you give us. **Please ask** if you do not understand any part. **Incomplete forms will be returned.**

Today's Date: \_\_\_\_\_ Date received (office use only) \_\_\_\_\_

### A) PATIENT DETAILS

Title: Mr/Mrs/Miss/Other:		Date of Birth:
Surname:	Forename:	
Address:		
Postcode:		
Telephone:		
HOME:	WORK:	MOBILE:
Gender:	NHS Number::	
MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		
Height.....	Weight.....	
If an interpreter is needed what language is spoken? _____		
Emergency contact name:	Relationship to patient:	
ADDRESS:	CONTACT NUMBER:	
POST CODE:		
Do you have a long-standing disability, illness or infirmity that limits your day-to-day activities?		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
If <b>Yes</b> , what is the nature of your disability? (e.g wheelchair user, visual or hearing impairment etc.)		
.....		

### B) GENERAL PRACTITIONER DETAILS

GP NAME:
ADDRESS:
TELEPHONE:

### C) MOBILITY

**Are you registered with Dial-a-Ride? Yes / No**      **Do you travel by car or taxi? Yes / no**  
**Do you attend a day centre? Yes/No** If 'Yes', please state name of day centre and days you attend.

**Are you registered with a mobility scheme? Yes / No**

**Please state your medical/physical reasons for being bedbound/chair-bound:**

### D) FOOT PROBLEMS

Please give **precise details** of your foot problem(s):

**If this section is left blank the form will be returned to the patient/sender.**

### E) GENERAL HEALTH DETAILS

**Please indicate with a tick** ✓

Do you have any medical problems? : Yes ☐ No ☐

If yes, do you have any of the following problems:

**Diabetes** ☐ **Heart / Circulation** ☐

**Rheumatoid Illness** ☐ **Chest / breathing** ☐

**Blood / bleeding** ☐ **Liver problems** ☐

**Kidney problems** ☐ **Cancer** ☐

Any other health problems not mentioned above?

\_\_\_\_\_

\_\_\_\_\_

## F) MEDICATION

Please indicate with a tick ✓

Do you currently take any medication, including tablets, creams, inhalers or injections? Yes ☐ No ☐

If 'Yes' please give details below


## G) REFERRAL DETAILS

(Please complete this section if you are referring someone other than yourself)

NAME:

DEPARTMENT / ORGANISATION:

ADDRESS:

TELEPHONE:

EXTENSION:

To help us provide a fair service to all the residents of Lewisham, please complete the section below.

What is your ethnic group? (please tick ONE box only ✓ )	
<b>White:</b>  <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other white background	<b>Black or Black British:</b>  <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background
<b>Mixed:</b>  <input type="checkbox"/> White and black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other Mixed background	<b>Asian or Asian British:</b>  <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background
<b>Chinese or other ethnic background:</b>  <input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group	<input type="checkbox"/> Not Disclosed
<p>This information is confidential and will be used by the service solely for monitoring purposes only. We are using the national standard based on the 2001 Census.</p>	