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| Image result for hse logo | **Dublin North City & County**  **Community Podiatry Service Referral Form** | Please return form to  EMAIL : [referrals.nd@hse.ie](mailto:referrals.nd@hse.ie)  FAX : 01 8953792  Alternatively post to  Community Healthcare Organisation  Dublin North City & County  Fujitsu House, Unit 100, 1st Floor  Lakeshore Drive, Airside Business Park  Swords, Co. Dublin, K67 R8X2 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | | | For Office Use: Date referral received \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | Priority: | | | | | | | | | | | | | | | | | | | | | | |
| Patient Name………………………………………………………………..  Patient Address……………………………………………..................  ………………………………………………………………….....................  DOB ……………………………………………………….Gender M / F  Phone No……………………………………………………...................  Next of Kin/carer contact details…………………………………  …………………………………………………………………………………….. | | | | | | | | | | | | | | | | | Medical card | | | | | | |  | LTI card | | | | | | |  | Other | | | |  | None | | | | | |  |
| GP Name……….….…………………………………………………………………  GP Address………………………………………………………………………….  …………………………………………………………………………………………….  ……………………………………………………………………………………………. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | | | | | | | | | | | Duration of Diabetes | | | | | | | | | | | | | | | | | | | | | | |
| Type 1 |  | Type 2 | | | |  | | Other | | | |  | | | | | | | | | | < 5 years | | | | | |  | | 5-10 years | | | | |  | | >10 years | | | | |  | | |
| Latest HbA1c | | | | | |  | | | | | | | | | | | | Date completed | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Foot Risk Categories | | | | | | Moderate | | | | | | | | | | | |  | | High | | | | | | |  | | |  | | | | | | | | | | | | | | |
| Non-Diabetic (Please indicate reason for high risk of ulceration/ amputation) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Peripheral Vascular Disease | | | | | | | | |  | | Rheumatoid Arthritis | | | | | | | |  | | Other | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical History | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current Medication  (Or Attach list) | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Smoker | | | | Yes | | | |  | | No | | |  | Units of alcohol Per week | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Anti-coagulation Therapy | | | | | | | | Yes | | | |  | No | |  | Does patient need Wheel Chair access | | | | | | | | | | | | | | | | | | | | Yes | | | |  | No | |  | |
| Reason For referral | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | |  | | | | | | | | | | | | | | Date | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Signature | | | | |  | | | | | | | | | | | | | | Profession | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Contact Number of referrer | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address of referrer | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the client consented to the sharing of Information | | | | | | | | | | | | | | | | | | | | | | | **YES** | | | | | |  | | | | | **NO** | | | | |  | | | | | |
| Has the client consented to this referral | | | | | | | | | | | | | | | | | | | | | | | **YES** | | | | | |  | | | | | **NO** | | | | |  | | | | | |

**Please refer to ‘model of care for the diabetic foot’ for categorisation via** [**www.hse.ie**](http://www.hse.ie) **(Pg 12)**

**Please provide additional information on the ‘diabetes foot screening tool’ (Pg. 15) All active diabetic foot disease must be referred to model 4 hospitals Incomplete referral forms will be sent back to referrer**

**FOR REFERENCE:**

Please refer to the table below for risk categorisation and referral pathways for patients with diabetes.

Please note that under the National Clinical Program for Diabetes, Foot Care Responsibility lies with Primary Care/Practice Nurse for Annual Low Risk Screening and Education.

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| **Risk Category (Priority)** | **Location** | **Referral Criteria for Diabetes Patients** |
| Active foot Disease | Hospital | Active foot ulcer, significant infection or suspected infection or suspected Charcot foot |
| High Risk | Community Podiatrist | Previous or recently healed ulcer, foot deformity with impaired sensation ischemia/neuroischaemia, infection/risk of infection or significant trauma to skin |
| Moderate Risk | Community Podiatrist | Patients presenting with one of the risk factors: Peripheral Arterial Disease, impaired sensation, foot deformity, significant pressure lesion or risk of infection or trauma to skin, visual impairment or physical disability (e.g. stroke or gross obesity) |
| Low Risk | Primary care | Patients presenting with normal tissue perfusion, adequate sensation, no deformity and no risk of infection |

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| **Location** | **Contact Name**  **and email** | **Phone Number** |
| Community/ Primary Care Centre | Angela Ferris  Angela.ferris@hse.ie | 01 921 4252 |