Laser Foot Care Of NY Referral Form

FORM IS COMPLETED LEGIBLY

Please return to: Laser Foot Care of NY, 1255 North Ave Suite 1E New Rochelle, NY 10804 Tel: 914-235-1000

This form must be completed fully by the **referring clinician** and sent to the address above. Incomplete or illegible referrals will be returned. Telephone referrals cannot be accepted. Please continue on the reverse if necessary.

Patient Details

NHS No. _____ Date of Referral _____

Name _____ Mr / Mrs / Dr. / Miss / Other :

Address _____ Date of Birth _____

_____ Post Code _____

_____

Tel No _____ Consultant (if applicable) _____

GP Name _____ Practice Name _____

Referrer _____ Position _____ Signature _____

Reason for Referral

Have you examined the patient yourself? Yes☐ No ☐

Please include specific foot & lower limb problems including the extent of pain, deformity, evidence of infection, history of ulceration, previous treatment and ability to self care

Patients referred for toenail cutting without both a clear clinical need and nail pathology will be offered group foot care education only. Does the patient have any difficulties which would make a group education session unsuitable for their needs (please Check):

Hearing Impairment ☐ Visual Impairment ☐ Other Disability ☐ Language Barriers ☐

What is the impact of the referral reason on the patient's quality of life?

Medical History & Current Medication

Please provide relevant details:

Domiciliary Care

If requesting a domiciliary visit for a patient, please tick to confirm that the patient is **incapable of travelling** in order to attend an appointment.

Patients who attend their GP or outpatient appointments unless in an ambulance are expected to also attend community clinics for appointments. Should the patient choose not to travel despite being capable, they will not be offered an alternative to a clinic appointment. ☐

Patients with transport difficulties should be advised to contact the Transport Access Patients Service for assistance.

Please continue here if you need to add any further information you feel we should know:

We would appreciate any relevant medical, social, disability and other needs or other information including language barriers you can provide to support meeting the patient's needs in advance of their first appointment

Office Use Only

	Date	Staff Initials	Reasons for return to Sender
Date Referral Form Received:			Please sign and date any comments:
Referral Form Complete/ Satisfactory: YES / NO	----------		
If **NO**: Date sent back to Referrer*:			
Date received back from Referrer:			
Date acknowledgement letter sent to Patient:			
Date acknowledgement Form sent to Referrer:			

*ensure copy is retained by Service

Referral Triage

Triage Score:		
Pathway decision including level of priority:		
Date & Time	Signature	Name & Designation Printed

Referral Quality Review (For audit purposes)	Y	N		Y	N
Was the initial referral acceptable/complete?	☐	☐	If stated, was the need for urgency correct?	☐	☐
If NOT, was the returned copy complete?	☐	☐	Was the referral reason accurate?	☐	☐
What was missing or the reason for returning the form?:			Was the referral appropriate?	☐	☐