Private & Confidential / Podiatry Department

Self-Referral Form

Please read accompanying leaflet 'Information for patients' before completing the self referral form. This leaflet will provide you with information on eligibility on accessing the Podiatry Service as well as self management options for your foot condition. On completion of your form please post to the following address or email to:

For Aberdeen City:

Podiatry Service
Aberdeen Health and Care Village
50 Frederick Street
Aberdeen, AB24 5HY
Email: gram.podiatryselfreferral@nhs.scot

For Aberdeenshire:

Podiatry Service
Staff Home
Upperboat Road
Inverurie Hospital
Inverurie, AB51 3UL
Email: gram.abdnshirepodforms@nhs.scot

For Moray:

Podiatry Service
The Glassgreen Centre
2 Thornhill Drive
Elgin, IV30 6GQ
Email: gram.moraypodiatry@nhs.scot

Your self referral will be reviewed by the Podiatrist and you will be contacted by letter with the outcome, this may include an assessment or self management options.

(Please include any images of the foot condition if possible when submitting this form).

1. Patient Details.

Patient Title and Name:		
Community Health Index (CHI):		
Date of Birth:	Contact by text message: Yes ☐ No ☐	
Address:		
Postcode:	Date:	
Telephone number:		

2. Have you recieved treatment from a podiatrist before?
(if yes please provide detail e.g. foot condition, location of podiatrist, etc).

Please give details:

3. Please describe your foot problem (e.g. duration of problem, type of pain experienced, self-treatment options used).

Please give details:

4. Do you have any existing medical conditions (e.g. Diabetes, Renal disease, Rheumatoid Arthritis).

Yes ☐ No ☐

Please give details:

5. Do you have any mobility concerns (e.g. use of walking aid, wheelchair, chair/bed bound).

Yes ☐ No ☐

Please give details:

6. To support the assessment of your referral the podiatrist would request access to your medical information contained within your key information summary.

Are you in agreement for the podiatrist to access this information? Yes ☐ No ☐

Patients Name:

This form has been completed by the patient ☐ Patient Representative ☐

Referral Received: Referral Completed: