Podiatry External Referral Form

Cleveland Clinic London

Please complete all known information on this form and email to CCLREFERRALS@ccf.org or fax to +44 (0)20 7890 4466

Patient Details	**GP Details**
Patient Name:	Full name:
Date of birth (DD/MM/YYYY):	Contact No.:
Gender Identity:	Email:
NHS No. (if applicable):	Street address:
Street address:	Postcode:
	Referrers Details
Postcode:	Full name:
Telephone/ Mobile:	Signature:
First language:	Date:
Interpreter required: Yes ☐ No ☐	Designation:
Infection control precautions:	Contact No.:

Medical Background
Medical History:
Medication:
Allergies:

Reasons for Referral	
☐ Diabetic foot screen	Referral priority: Urgent ☐ Routine ☐
☐ Foot wound	Infection: Yes ☐ No ☐
☐ Gangrene / Necrosis	Is the patient on antibiotics?: Yes ☐ No ☐
☐ Suspicion of osteomyelitis	If yes please state name/dosage/duration:
☐ Red / Hot / Swollen foot /Active charcot	**Exclusion Criteria**
☐ Ingrowing toenail	• Paediatric patients
☐ Corns / Callus	• Verrucae/warts
☐ Gait / Biomechanics	• Lymphoedema/venous leg ulcers
☐ Other (please specify)	• Soft tissue mass/tumours
	• Foot deformity requiring surgical intervention