**ELIGIBILITY CHECKLIST**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Is the patient in need of a clinical podiatry service for any of the following?** | | | |  |  |  |  |
| Athlete’s Foot | Corns or callous | Verrucae | Infection |  |  |  |  |
| Pain in leg, knee, ankle or heel | | In-growing toenail | Other | Yes |  | No |  |
| If yes, the patient should be referred to the Podiatry service. | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does the patient have diabetes?** | Yes |  | No |  |
| If yes, the patient will not be eligible for the NHS simple nail cutting service unless they are considered to be a low risk diabetic by their GP. |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Is the patient able to self-care (i.e. cut their own toenails)?** | | | | | Yes |  | No |  |
| If yes the patient is not eligible for the NHS simple nail cutting service. | | | | |  |  |  |  |
| If no, please indicate why not and provide any relevant details in the box below: | | | | |  |  |  |  |
| Arthropathy affecting dexterity and / or flexibility | | | Visual impairment | |  |  |  |  |
| Physical disability | Learning disability | Breathing problems | | Other |  |  |  |  |
| Details: | | | | |  |  |  |  |
|  | | | | |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does the patient have a relative / regular carer who could cut their toenails?** | Yes |  | No |  |
| If yes the patient is not eligible for the NHS simple nail cutting service. |  |  |  |  |

**PATIENT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forename(s) |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NHS No |  | Date of Birth |  | Male | Female |

|  |  |
| --- | --- |
| Address |  |

Contact Telephone Number Name : Number:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient |  | \*NOK |  |  |  |

**Mobility Status** Please tick any of the following that apply.

|  |  |
| --- | --- |
| The patient is able to attend the clinic | The patient is only able to attend if transport is provided |
| The patient uses a wheelchair | The patient is housebound |

**Ethnicity**

Please provide the ethnicity of the patient. This ensures that we are providing services that meet the needs of the local population.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **White** | British |  | Irish |  | Other European |  | White other |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Black/Black British** | Black Caribbean |  | Black African |  | Black Other |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Asian/Asian British** | Indian |  | Pakistani |  | Bangladeshi |  | Asian Other |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mixed** | White and Black Caribbean |  | White and Black African |  | White and Asian |  | Mixed Other |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Other** | Chinese |  | Any Other Group |  | Refused to Say |  | Unknown |  |

**Language**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Is a translator required? | Yes |  | No |  | If yes, please state language |  |

**Medical History / Medication**

Please give details of any medical conditions or medications the patient is currently taking which you feel should be brought to the attention of the Basic Foot Care service.

|  |  |
| --- | --- |
|  |  |

**GP DETAILS**

|  |  |
| --- | --- |
| Doctor’s Name |  |

|  |  |
| --- | --- |
| Doctor’s Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Telephone |  | Fax |  |

**REFERRAL**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Referred By | GP |  | Other |  | If other, please state |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Referrer (if not GP) |  | Date of Referral |  |

**CONSENT (If referral comes from GP/Health Professional –consent must be obtained by them as the Data Controller. For self-referrals AUKC must obtain and record consent)**

Client consents to Age UK Kensington and Chelsea storing personal details and treatment notes in accordance with the EU’s General Data Protection Regulation (GDPR) Yes [ ] No [ ]

Consent obtained over the telephone? Yes [ ] No [ ]

Date of Consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signed­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please return this completed form BY FAX to:**  Age UK Kensington & Chelsea, Basic Foot Care Service, Unit 24, 10 Acklam Road, London W10 5QZ | | | | | |
| Telephone | **020 8960 8137** | Fax | **020 3489 4962** | Email | **ageuk.basicfootcare@nhs.net** |

|  |
| --- |
| **What is your preferred form of contact?** |
| **Phone:** |
| **Letter:** |
| **Email:** |
| **Please tick above** |
|  |