**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 andAsian |[ ]  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’sAddress |   |

|  |  |  |  |
| --- | --- | --- | --- |
| 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** |
|  |