MN291

Queensland Government

Metro North Hospital & Health Service

PODIATRY REFERRAL: FOOT DISEASE & HIGH-RISK SERVICE

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Telephone:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Reason for referral – *tick all that apply* **Date of referral:** ___/___/___

Foot Disease: ☐ Foot ulcer (superficial) ☐ Foot ulcer (suspected deep - probe to tendon, joint or bone)

☐ Pressure injury: Stage:........ Location foot ulcer or pressure injury:........

☐ Suspected or acute Charcot neuroarthropathy (red, hot, swollen foot)

Is Foot Infection present: ☐ No ☐ Yes: Details: ☐ Mild ☐ Moderate ☐ Severe (REFER to Emergency)

Antibiotic therapy intiated: ☐ No ☐ Yes: Details:........

High Risk Foot: ☐ Loss of protective sensation ☐ Peripheral artery disease

☐ Previous foot ulcer ☐ Previous lower-extremity amputation (minor or major) ☐ End-stage Kidney Disease

Other relevant information (e.g. ulcer duration / cause, recent treatments, recommendations):

Medical information ☐ ***GP Health Summary attached***

Allergies: ☐ Nil Known

Alerts / Risks (e.g. MRSA, mobility, cognitive status): ☐ Nil known

Recent investigations (e.g. x-ray, pathology – please include with referral):

☐ X-ray ☐ MRI ☐ Bloods ☐ HbA1c ☐ Other:........

Does the client require an interpreter: ☐ Yes: Language - .... ☐ No ☐ Unknown

Healthcare Providers – *relevant to foot health*

GP name:........ GP Practice:........

Phone:........ Fax:........ Email:........

☐ Medical/Surgical Specialist ☐ NGO Nursing ☐ Diabetes Educator ☐ Private Podiatrist

☐ Other:........

Details:

Alternative / emergency contact

Name:........ Phone:........

Relationship to client:........

Referrer details

Name:........ Practice:........

Phone:........ Fax:........ Email:........

REFERRAL SUBMISSION: Metro North Central Patient Intake Unit **Ph**: 1300 364 938 **Fax**: 1300 364 952 or **eReferral**

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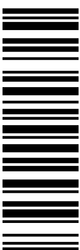

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