Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CLIENT WILL BE PRIORITISED BASED ON THE INFORMATION GIVEN, MEDICAL HISTORY AND REASON FOR REFERRAL

MERLIN PARK PODIATRY CLINIC - REFERRAL FORM

Name:

Address:

Date of Birth: ___/___/___

Phone no:

Medical Card Number:

MEDICAL HISTORY:

MEDICATION:

REASON FOR REFERRAL: Please indicate if any of the following conditions are present:

Skin conditions:		**Toe nail conditions:**		**Biomechanical conditions:**		**Other:** ☐
Corn	☐	Ingrowing	☐	Rearfoot/Arch Pain	☐	(please comment)
Callus	☐	Infected	☐	Forefoot Pain	☐	
Verrucae	☐	Thickened	☐	Toe deformities	☐	
Tinea pedis	☐	Fungal	☐	Gait abnormalities	☐	

COMMENTS:

RISK STATUS: (please tick)

HIGH RISK		**MEDIUM RISK**		**LOW RISK**	
Current Foot Ulcer	☐	Neuropathy	☐	No deformity	☐
Current Infection	☐	PAD	☐	No neuropathy	☐
Charcot Foot	☐	Foot deformities	☐	No PAD	☐
		Previous Ulceration	☐		

Referrer Name:

Address:

Signature:

Referrer Stamp:

Please complete the form in full and send to: **Merlin Park Podiatry Clinic, Merlin Park Hospital, Galway 091 731480**