Health
South Eastern Sydney
Local Health District

THE SUTHERLAND HOSPITAL PODIATRY REFERRAL FORM

PLEASE EMAIL TO:	SESLHD-SouthCareIntake@HEALTH.NSW.GOV.AU		
	Or fax: 02 9540 7869		
PATIENT DETAILS	SURNAME: Click here to enter text.	GIVEN NAME(S): Click here to enter text.	
	DOB: Click here to enter text.	MALE ☐ FEMALE ☐	MRN: Click here to enter text.
	ADDRESS: `		
	PHONE NO:	WORK: Click here to enter text.	MOBILE: Click here to enter text.
	LIVING ARRANGEMENTS: Alone ☐ Hostel ☐ with Spouse ☐ with Family ☐ Other: Click here to enter text.		
	ABORIGINAL OR TORRES STRAIT ISLANDER: YES ☐ NO ☐		
	PREFERRED LANGUAGE:	INTERPRETER REQUIRED: YES ☐ NO ☐	
PREFERRED CONTACT (if not patient)	CONTACT NAME: Click here to enter text.	RELATIONSHIP TO PATIENT: Click here to enter text.	
	CONTACT'S PHONE NO: HOME: Click here to enter text.	MOBILE: Click here to enter text.	
GP DETAILS	GP NAME:	GP PHONE NUMBER:	
	GP ADDRESS:		
MEDICAL HISTORY	**PLEASE ATTACH A FULL MEDICAL HISTORY & MEDICATIONS LIST WITH THIS REFERRAL**		
CLINICAL INFORMATION	PLEASE TICK:		
	PERIPHERAL VASCULAR DISEASE ☐ YES ☐ NO	PERIPHERAL NEUROPATHY ☐ YES ☐ NO	
	ACTIVE FOOT ULCER/INFECTION ☐ YES ☐ NO	PREVIOUS LOWER LIMB AMPUTATION ☐ YES ☐ NO	
	CHARCOT FOOT ☐ YES ☐ NO	CHRONIC INGROWN TOENAIL/S ☐ YES ☐ NO	
TREATMENT REQUIRED	ULCER MANAGEMENT ☐ YES ☐ NO	CHARCOT MANAGEMENT ☐ YES ☐ NO	
	DIABETES FOOT ASSESSMENT ☐ YES ☐ NO	INGROWN TOENAIL SURGERY ☐ YES ☐ NO	
COMMENTS			
REFERRED BY:	NAME:	PHONE: Click here to enter text.	
	SIGNATURE: Click here to enter text.	DATE:	
	Provider Number: Click here to enter text.		

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