

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 <input type="checkbox"/> FEMALE <input type="checkbox"/> MRN: Click here to enter text.
	ADDRESS: `		
	PHONE NO:	WORK: Click here to enter text.	MOBILE: Click here to enter text.
	LIVING ARRANGEMENTS: Alone <input type="checkbox"/> Hostel <input type="checkbox"/> with Spouse <input type="checkbox"/> with Family <input type="checkbox"/> Other: Click here to enter text.		
	ABORIGINAL OR TORRES STRAIT ISLANDER: YES <input type="checkbox"/> NO <input type="checkbox"/>		
	PREFERRED LANGUAGE:		INTERPRETER REQUIRED: YES <input type="checkbox"/> NO <input type="checkbox"/>
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	<u>PLEASE ATTACH A FULL MEDICAL HISTORY & MEDICATIONS LIST WITH THIS REFERRAL</u>		
CLINICAL INFORMATION	PLEASE TICK:		
	PERIPHERAL VASCULAR DISEASE <input type="checkbox"/> YES <input type="checkbox"/> NO		PERIPHERAL NEUROPATHY <input type="checkbox"/> YES <input type="checkbox"/> NO
	ACTIVE FOOT ULCER/INFECTION <input type="checkbox"/> YES <input type="checkbox"/> NO		PREVIOUS LOWER LIMB AMPUTATION <input type="checkbox"/> YES <input type="checkbox"/> NO
TREATMENT REQUIRED	CHARCOT FOOT <input type="checkbox"/> YES <input type="checkbox"/> NO		CHRONIC INGROWN TOENAIL/S <input type="checkbox"/> YES <input type="checkbox"/> NO
	ULCER MANAGEMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		CHARCOT MANAGEMENT <input type="checkbox"/> YES <input type="checkbox"/> NO
	DIABETES FOOT ASSESSMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		INGROWN TOENAIL SURGERY <input type="checkbox"/> YES <input type="checkbox"/> 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.		

The information contained in this facsimile is confidential and is safeguarded by Legislation. It is intended for receipt only by the named addressee. If you are not the named addressee, any use, disclosure, copying or distribution of the facsimile or any of the information contained in it is prohibited. Please let us know immediately by telephone if you have received this communication in error, so that we can arrange for it to be returned (phone number 02-9540 7175).

Sutherland Hospital Podiatry Clinic
Allied Health Department
The Sutherland Hospital
Cnr The Kingsway and Kareena Rd
Caringbah 2229
Ph: 9540 8300