



<b>Section 2</b>		
Are you unable to work or care for a dependant because of this problem? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Are you in paid employment (including self-employment)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Are you off work due to this problem? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes how long have you been off work?		
<b>Have you experienced/are you experiencing any of the following? (Important: If answering yes to any of the following please give details in box C on page 1)</b>		
1	A history of cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Recent weight loss <b>of over 10kg</b> without trying	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	New or recent loss of control of your bladder and/or bowels or difficulty passing urine	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Pins and needles or numbness around your back passage or genitals e.g. when wiping after toilet	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Unexplained tripping, stumbling or arm or leg weakness	Yes <input type="checkbox"/> No <input type="checkbox"/>
6	Recent sudden change in the shape of your ankle or foot	Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Any heat, redness and swelling of your calf/joints/other (please circle any which apply)	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	Feeling generally <b>very</b> unwell	Yes <input type="checkbox"/> No <input type="checkbox"/>
9	Recent history of significant injury/trauma (please give details in box C on page 1)	Yes <input type="checkbox"/> No <input type="checkbox"/>
10	Foot or ankle pain improved by any medication you currently take	Yes <input type="checkbox"/> No <input type="checkbox"/> n/a <input type="checkbox"/>
11	A history of any of the following: IV drug use/HIV/osteoporosis/TB (Please circle any which apply)	Yes <input type="checkbox"/> No <input type="checkbox"/>
12	Have you contacted your Doctor or other health professional about your current foot and ankle problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>
13	Are you or could you be pregnant? (please give number of weeks)	Yes <input type="checkbox"/> No <input type="checkbox"/>  Weeks:
14	Have you had an x ray or scan for this problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you able to access the internet? Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>GENERAL HEALTH:</b> Please tick if you have any of the following: Good Health <input type="checkbox"/>		
Diabetes <input type="checkbox"/>	Foot/Leg Ulcers <input type="checkbox"/>	Rheumatoid condition <input type="checkbox"/>
Poor Circulation <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Foot/Leg/Toe amputation <input type="checkbox"/>
Other:		

<b>Do you have any other health problems you think we should be aware of? E.g. allergy</b>
<b>Please list your current medications including any over-the-counter products:</b>
<b>Lifestyle :</b> Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> Number of cigarettes smoked per day? Approximately how many units of alcohol do you drink per week? Do you take regular exercise? Yes <input type="checkbox"/> No <input type="checkbox"/> Type of exercise taken?
<b>Section 3 – Please fill in this section only if you have contacted us about this problem before. What is the reason you are contacting us again? (please tick any that apply)</b>
Problem getting worse <span style="float: right;"><input type="checkbox"/></span> Problem not improving despite following self help advice <span style="float: right;"><input type="checkbox"/></span> GP or other health care worker told me to contact again <span style="float: right;"><input type="checkbox"/></span> New Problem <span style="float: right;"><input type="checkbox"/></span>  I confirm I have tried the recommended self care for this problem <span style="float: right;"><input type="checkbox"/></span>
<b>Signature:</b>
<b>Date:</b>

Please send this completed form to:

AHP Booking Team  
 AHP Support Office (Room 1GW8)  
 Borders General Hospital  
 TD6 9BS

**What happens next?**

Once we receive your completed form we will carefully check all the information and decide how best to help you based on the information you provide. If we need more information to enable us to make a decision then someone will contact you by telephone or email. If we think your problem would be better managed by a different health care professional we will pass the referral to them (e.g. physiotherapist or GP). To allow us to give you the best care it is very important you give us clear information especially in relation to the reason for your referral on page 1 (see our example of a completed form for help with the kind of information needed).

The help we offer may take the form of advice on things you can do yourself to improve your symptoms, e.g. by directing you to our website:

[www.nhsborders.scot.nhs.uk/commonfootandankleproblems](http://www.nhsborders.scot.nhs.uk/commonfootandankleproblems).

(If you have no internet access we can send you a leaflet). Alternatively you may be offered a clinic appointment. By working in this way our patients have fast access to evidence-based up-to-date information without needing to wait for a clinic appointment. Clinic appointments can also be offered quickly to those who have conditions putting them at higher risk of developing foot and ankle complications.

If you are advised to try self help and find that despite following our advice your foot and ankle problem is not improving within the suggested time frame we ask that you complete another self-referral form. We will then contact you to decide how best to help you.