

**Podiatry Department clinic application form**  
**Edinburgh, East Lothian and Midlothian CHPs**



Based on the information supplied, you may be invited to a group presentation to help you with your foot problem. **Incomplete forms will be returned.**

**The podiatry department does not offer a nail care or cutting service in the absence of any medical or podiatric need. Home visits are by GP referral only.**

Title: Mr/Mrs/Miss/Ms	First name:	Surname:
Address:		Date of birth:
		Postcode:
Home phone:	Work phone: (optional)	Mobile phone:
GP name and Practice:		
Emergency contact details: Name Address		Relationship Phone no:
Do you require an interpreter?      Yes <input type="checkbox"/> Language      No <input type="checkbox"/>		
How long have you had this complaint?      Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/>		
Are the symptoms worsening?      Yes <input type="checkbox"/> No <input type="checkbox"/>		
Are you off work or unable to care for a dependant because of this problem? 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 arthritis <input type="checkbox"/>
Poor circulation <input type="checkbox"/>	Heart disease <input type="checkbox"/>	Foot/Leg amputation <input type="checkbox"/>
Other:		
<b>MEDICATIONS</b> None <input type="checkbox"/>		
Please list all medications/tablets you are taking:		
<b>FOOT HEALTH</b>		
Please tick if you suffer from any of the following:		No pain <input type="checkbox"/>
Infection or ulcer <input type="checkbox"/>	Ingrowing toenail <input type="checkbox"/>	Thickened nails <input type="checkbox"/> Painful corns <input type="checkbox"/>
Heel pain <input type="checkbox"/>	Pain on walking <input type="checkbox"/>	Joint pain in feet <input type="checkbox"/> Verrucae <input type="checkbox"/>
Unable to cut nails <input type="checkbox"/>	Fungal nails <input type="checkbox"/>	
Please give a brief description of why you feel you need a foot assessment:		

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**Please note your preferred appointment day and time.**

Please note that not all clinics offer a five days a week service.

Monday am/ pm Tuesday am/ pm Wednesday am/ pm Thursday am/ pm Friday am/ pm

Additional information:

**LIST OF CLINICS**

<b>EDINBURGH SECTOR</b>			
<b>CLINIC</b>	<b>ADDRESS</b>	<b>TEL NO</b>	<b>TICK</b>
Gracemount H.C.	24 Gracemount Drive, EH16 6RN	0131 672 9488	
Inchkeith House	139 Leith Walk, EH6 8NP	0131 537 4550	
Mountcastle H.C.	132 Mountcastle Drive South, EH15 1PZ	0131 549 7335	
Sighthill H.C.	380 Calder Road, EH11 3PF	0131 537 7146	
South Queensferry	41 The Loan, EH30 9HA	0131 537 4441	
Springwell House	26 Ardmillan Terrace, EH11 2JL	0131 537 7470	
Stockbridge H.C.	1 India Place, EH3 6EH	0131 260 9200	
Tollcross M.C.	Ponton Street, EH3 9QQ	0131 536 9746	
<b>EAST LOTHIAN SECTOR</b>			
<b>CLINIC</b>	<b>ADDRESS</b>	<b>TEL NO</b>	<b>TICK</b>
Cockenzie H.C.	Avenue Road , EH32 0JL	01875 818 584	
Dunbar M.C.	Queens Road, EH42 1EE	01368 861 419	
Gracefield Clinic	Gracefield Car Park Musselburgh, EH21 6LL	0131 665 4030	
Haddington Clinic	Newton port, EH41 3NF	01620 826 719	
North Berwick H.C.	St Baldred's Road, EH39 4PU	01620 897 010	
Prestonpans H.C.	Preston Road, EH32 9QS	01875 818 076	
Tranent H.C.	Loch Road, EH33 2JX	01875 618 953	
<b>MIDLOTHIAN SECTOR</b>			
<b>CLINIC</b>	<b>ADDRESS</b>	<b>TEL NO</b>	<b>TICK</b>
Bonnyrigg H.C.	109-111 High Street, EH19 2DA	0131 537 9857	
Dalkeith M.C.	25 St Andrews Street, EH22 1AP	0131 561 5563	
Danderhall M.C.	Newton Church Street, EH22 1QL	0131 654 1079	
Gorebridge M.C.	15 Hunterfield Road, EH23 4TP	01875 823 740	
Loanhead Clinic	17 George Terrace, EH20 9JZ	0131 440 4612	
Newbattle M.C.	Blackcot Road, Mayfield, EH22 4AA	0131 561 9243	
Penicuik H.C.	37 Imrie Place, EH26 8LF	01968 671 520	

**Please return this form to the clinic indicated above.**

**An appointment will only be sent when the form is fully completed and returned.**

**FOR OFFICE USE**

**Date received .....**

**Date and time of assessment.....**

**Date assessed ..... Patient number .....**