Health
Nepean Blue Mountains
Local Health District

NSW GOVERNMENT

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

HIGH RISK FOOT SERVICE REFERRAL

Please fill out all fields below and attach GP/Specialist medical condition summary as well as:

- ☐ **List of current medications**
- ☐ **Recent pathology (within the last 3 months — FBC, EUC, CRP, ESR, HbA1c, fasting lipids)**
- ☐ **Recent imaging (x-rays, CT, MRI, arterial studies)**
- ☐ **Relevant specialist letters**

Ph: 02 47342959 Fax: 02 47341122 **Email: *NBMLHD-HRFSReferrals@health.nsw.gov.au***

☐ **Dr Anna Zheng (or equivalent practitioner)** ☐ **High Risk Foot Service (any doctor available on the day)**

Dear Doctor

Thank you for seeing _____ (full name), DOB: ____ /____ / _____

Address: _____

Person to Contact: _____ Person to Contact Telephone Number: _____

Is this person Aboriginal and/or Torres Strait Islander Origin? ☐ Neither ☐ Aboriginal ☐ A&TSI ☐ Torres Strait Islander

Interpreter required? ☐ No ☐ Yes Language Spoken if other than English _____

Reason for referral:

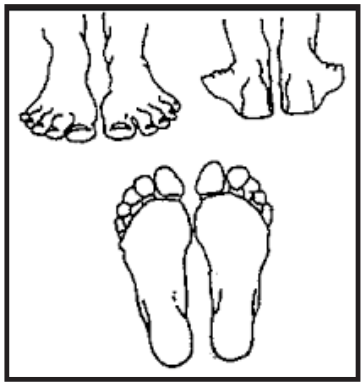
☐ Non-healing foot ulcer or foot wound
- Date of onset ____ /____ / _____
- Foot ulcer suspected to be deep (probe to tendon, joint or bone) ☐ Yes ☐ No
- Foot ulcer superficial or non ischemic ☐ Yes ☐ No
- Foot ulcer is infected ☐ Yes ☐ No

☐ Suspected Osteomyelitis or soft tissue infection of the foot
- Is spreading cellulitis also present? ☐ Yes ☐ No

☐ Critical limb ischemia

☐ Suspected or diagnosed acute Charcot Neuroarthropathy

☐ Gangrene of the lower limb



Please indicate the location of concern on the foot diagram.

Additional detail regarding reason for referral: _____

_____

_____

Smoker? Ever Smoked ☐ No ☐ Yes Current smoker ☐ Yes, pack/year _____

Alcohol Use? ☐ No ☐ Yes, please provide details _____

Medical History: Does the patient have any of the following: (tick box if "Yes")

☐ Diabetes Mellitus. Please state type and duration: _____

Diabetes Mellitus medication type and dosage: _____

Does the patient have an Endocrinologist? ☐ No ☐ Yes, please provide details _____

☐ Peripheral vascular disease ☐ Previous ulceration ☐ Immunocompromised ☐ Cardiovascular disease

☐ Chronic Kidney Disease ☐ Previous amputations ☐ Cognitive Impairment

Please provide additional details re the specified conditions: _____

_____

Referrer Name: _____ **Referral Date:** _____

Referrer Position: _____ **Provider Number:** _____

Practice: _____ **Phone:** _____ **Fax:** _____

Signature: _____

Please scan and send this referral with required attachments

HIGH RISK FOOT SERVICE REFERRAL

NBMHR-0220

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

100821