**Nurses 4 Feet – Foot Care Referral Request for Patient Evaluation**

**Date:**

**Patient Information:**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth (DD/MM/YYYY):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Health Care Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Request for Physician’s Note:**

* **Patient requires foot care for the following duration:**
[ ] 1 Year
[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_ (Please specify duration)

**Please check box to confirm patient requires Foot Care**

* **[ ]** Patient has **diabetes** or related complications requiring foot care.
* **[ ]** Patient has **peripheral vascular disease** requiring foot care.
* **[ ]** Patient has **high-risk foot conditions** (e.g., wounds, ulcers).
* **[ ]** Patient has **chronic foot pain** or deformities requiring treatment.
* **[ ]** Patient has **nail care needs** (e.g., ingrown nails, fungal infections).
	+ **[ ]** Due to **advanced age**, **physical weakness**, **impaired dexterity**, or **reduced mobility**, the patient is unable to safely care for their own feet.

**Physician Information:**

* **Physician’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Fax Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Signature & Date**

By signing below, I confirm that the patient named above requires foot care as outlined in the selected category.

* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax completed form back to: Nurses 4 Feet Fax: 1.587.316.6319**