**Nurses 4 Feet**

High Risk Foot Care Team

RN, LPN, OT

C: 587.726.2783

F: 587.316.3961

High Risk Foot Care Request Form

|  |
| --- |
| **Personal Information** |
| First Name: GAEDANE Last Name: GervaisDate of Birth: \_\_\_dd \_\_\_\_\_mmm \_\_\_\_\_\_yyyyAddress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_Home Phone #: (\_\_\_\_\_) \_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_ AB Health Care #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Reason For Referral** |
| Today’s main concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Previous foot care/wound treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you diabetic? Yes No Type I Type II Do you have neuropathy or numbness/tingling in your feet? Yes No Have you ever had a leg or foot circulation test (ABI)? Yes No Medications/Supplements: Name Dose Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current foot problems (check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| Athlete’s Foot | Claw Toes | Fungus  | Plantar Fasciitis |
| Blisters | Corns | Gout  | Sweaty Feet |
| Bunions | Dry skin | Hammer Toes | Thickened Nails |
| Calluses | Fissures | High Arch | Ulcers |
| Cellulitis | Flat Feet  | Ingrown Toenails | Warts |
| Charcot Foot | Fractures | Mallet Toes | Yellow Nails |

Primary Foot Concerns: *(Please list all health conditions you are currently being treated for or are a concern to you at this time)**)* |