**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

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| **Personal Information** |
| First Name: GAEDANE Last Name: Gervais  Date of Birth: \_\_\_dd \_\_\_\_\_mmm \_\_\_\_\_\_yyyy  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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)*  *)* |