Podiatry Referral Form

Patient Details

Name: __________________________________________
Address:                                                                                           
Date Of Birth: _____ / _____ / _____
Medicare No: ____________________________

Presenting Complaints

Treatment(s) Required (see list on right)

Referring Doctor’s Details

Doctor’s Name: ________________________________________
Address:                                                                                           

Signed: _______________ Date: ___ / ___ / ___

Patient Health Cover

☐ Private: ________________________________
☐ Medicare Team Care Arrangement (Visits: ___ / 5)
☐ DVA / D904
☐ WorkCover Queensland
☐ Other: ________________________________

Please bring along...

☐ This referral form
☐ Foot, leg or back X-rays
☐ Appropriate clothing for lower limb assessment
☐ Medical history and medication list
☐ Private health fund card (if applicable)
☐ Medicare card (for Team Care Arrangements)

☐ Routine Footcare (skin and nail care)
☐ Custom Foot Orthotics
  □ Rigid □ Soft □ UCBL
☐ Orthotic Bracing
  □ SMO □ Solid AFO □ Articulated AFO
☐ Orthopaedic Footwear
  □ Custom □ Prefab □ Modified Prefab
☐ Footwear Modifications ____________

☐ Splints (hallux valgus, plantar fascial)
☐ Diabetic Footcare (annual neurovascular assessment, ABI/Doppler, ulcer Mx)
☐ Sports Injury Management
☐ Minor Surgery
  □ Ingrown Toenail □ Wart
☐ Post Surgical Rehabilitation and Aids
☐ TAG Brace (100% Foot Offloading)
☐ Extracorporeal Shockwave Therapy

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