

## RCHS Foot Care/High-Risk Chiropody Referral Form

**\*\*Please note that all incomplete forms will be returned to the referring provider for more information and all client referrals will be triaged based on the information provided\*\***

Referring Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number (**\*required**): \_\_\_\_\_ Request communication back?  Yes  No

### Client Information:

Client Name: \_\_\_\_\_ Gender:  M  F DOB (DD/MM/YYYY): \_\_\_\_\_

Address: \_\_\_\_\_

Client Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Client has:**  Diabetes  Vascular Disease (M.I. / Stroke, PVD, etc.)  Other Chronic Illness

**Referral for:**  Open wound/foot ulcer or infection (high priority)

- Advanced Foot Problem (i.e. heavy calluses, corns, fragile skin with pressure lesions, thick nails, cracked skin, reddened areas with localized foot pain, etc.)
- Basic Foot Care (i.e. nail care, callous care, foot care education, etc). **Note:** this program is only available to adults with a chronic health condition, no benefit coverage and who face financial barriers to accessing fee for service foot care programs.

Please attach relevant client information including client profile, med list, allergies/drug sensitivities, etc.

### Details of Foot Problem:

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Please Fax *Completed* Referral to: **613-284-2591**