**CSH Single Point of Access (SPA) Community Service Referral Form**

*\*Mandatory field must be completed for referral acceptance*

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| **\*Podiatry** | | | |
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**Please note that the podiatry service has exclusions and does not accept referrals from individuals who**:

* Do not have a foot health problem
* General nail care including fungal and thick nails
* Corns and/or callus with no associated medical risk factors.
* Have problems that are caused or aggravated by inappropriate footwear
* Have verrucae/plantar warts

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| **\*Personal Details** |  |
| Surname: | Mr Mrs Miss |
| Forename: | Date of Birth: |
| Address: | NHS No: |
| Home Telephone Number: | Mobile: |
| Does the patient have any communications needs for spoken communication? | YES/NO (if Yes please detail) |
| Does the patient have any communication needs for written communication? | YES/NO (if Yes please detail) |
| GP Name, Address & Telephone Number: | |

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| **\*Ethnicity:** |
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| **\*Reason for Referral *(failure to complete giving detailed information will result in the referral being returned to the applicant)*:** |
| **\*PLEASE ATTACH PHOTOGRAPH OF PROBLEM AREA IF POSSIBLE\*** |
| **\*Medical History and List of Current Medication:** |
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| **\*Are you able to attend an outpatient appointment?:**  YES/NO (if no please detail why) |
| **Urgent:** YES/NO (If Yes, please detail why) |

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| **\*Consent:** |
| Has consent been obtained for this referral? YES/NO  Please detail third party consent if applicable: |

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| **\*Signature of applicant / referrer:** |
| Name: Signature: |

Please send completed form to: **CSH Single Point of Access (SPA)**

Woking Community Hospital

Heathside Road

Woking

GU22 7EY  
Email: [CSH.SPAreferrals@nhs.net](mailto:CSH.SPAreferrals@nhs.net)

Tel: 0330 726 0333

Website:[www.cshsurrey.co.uk](http://www.cshsurrey.co.uk/)

SPA Opening Hours: Monday-Friday: 8am - 6pm