



**DIABETES "HOSPITAL HIGH RISK FOOT TEAM"
REFERRAL FORM**

PATIENT INFORMATION:

HOSPITAL NUMBER: _____

GP NAME: _____

NAME: _____

GP ADDRESS: _____

DATE OF BIRTH: _____

ADDRESS: _____

GP TELEPHONE No _____

PATIENT'S OCCUPATION: _____

TELEPHONE No: _____

MALE OR FEMALE: _____

PRESENTING PROBLEM: (PLEASE TICK ALL APPLICABLE)

**CURRENT
MEDICATIONS
& ALLERGIES
(PLEASE LIST):**

DIABETES WITH:

CURRENT FOOT ULCERATION
Site of Ulceration: _____

INFECTION / CELLULITIS
Site: _____

OSTEOMYELITIS / OTHER BONEY INVOLVEMENT
Site: _____

CHARCOT FOOT/ OTHER FOOT DEFORMITY
Please state: _____

COMMENTS:

**REFER TO HOSPITAL PODIATRIST:-
JAZZ HILLMAN
WAIKATO HOSPITAL
DIABETES CLINIC
PODIATRY SERVICES
TEL: 07 839 8701
FAX: 07 839 8811**

REFERRED BY: _____

POSITION: _____

SIGNATURE: _____

TELEPHONE: _____

DATE: _____

**HbA1C – (MOST
RECENT RESULT):**