|  |  |
| --- | --- |
| **Referral for Podiatric surgery**  Date Practice | |
| Patient name Referring practitioner | |
| I am referring this patient for a surgical opinion on;   |  |  |  | | --- | --- | --- | | Bunions | Hammer toes | Heel  pain/fasciitis | | Neuroma | Skin lesion | Nail pathology | | Warts | Toe pain | Midfoot pain | | Cavus feet  Other ; | Ankle  pain / instability | Flat feet | | Have current imaging examinations been performed?  (X-rays, Ultrasound C.T., MRI)    Yes No  Standard X-ray views;  *A.P. & Lateral weight bearing and erect, Medial-oblique non-weight nearing* |
| Medical conditions | |
| Medications Allergies | |
| Clinical history | |
| Previous treatment | |