The SOCIETY of CHIROPODISTS & PODIATRISTS

Betafeet Podiatry

Consent for Podiatry Treatment

Patient Name:

DoB:

Patient agreement to Podiatry Treatment

Title … Patient's Surname: ..... First name: ……..... Date of birth: ….....

Address …… Post Code ……

Tel: .....……Mobile …… Email……...

Consent to being treated by a Podiatrist

I understand that I am to be seen/treated by a Podiatrist. ☐

I confirm that I am aware that Podiatrists may use sharp medical instruments. ☐

I understand that my data is stored in a cloud database system which is password protected. ☐

I confirm that I understand the cancellation or no shows policy: ☐

(If you wish to cancel or reschedule an appointment, we simply ask you to give a minimum of 24 hours' notice for up to 30 minute appointments and 48 hours' notice for our longer appointments such as our biomechanical assessments and nail surgery. If this minimum is not adhered to, we reserve the right to charge the full treatment cost of the appointment. We appreciate there may be extenuating circumstances that prevent your attendance. Let us know immediately)

Are there any changes to your health or medication? (*If yes, please state health or medication changes)* **Yes/No**

……..

I consent to Betafeet Podiatry contacting me by text message or email for appointment reminders **Yes/No**

(You can cancel this service at any time. Text messages and emails are not always secure. The practice will not transmit any information which would enable an individual to be identified. This MUST NOT be a work email address. Reminders can sometime go askew therefore it is the patients are responsible for checking appointment dates and times to ensure appointments are not missed).

To be completed by the patient:

Consent given is in-light-of full information of risk of failure or complication as well as alternative therapies available.

Planned Procedure after discussion with Podiatrist:……

I agree to have the treatment I have been told about; **Date** ..... / ..... / .....

Signed ..... Name (PRINT) .....

Agreement to Podiatry Treatment by a Podiatrist when patient's aged 17 or younger OR lack capacity to consent

To be completed by the parent or guardian:

I am the patient's parent/guardian and I confirm that the procedure has been satisfactorily explained; I have raised any questions or concerns which I have about the proposed treatment; and I consent to the procedure/treatment referred to above.

Parent's or guardian signature ..... Date ..... / ..... / .....

Name (PRINT) …… Relationship to patient .....

To be completed by the podiatrist:

- I am satisfied that the patient **HAS** capacity ☐
- I am satisfied that the patient does **NOT** have capacity to give consent and recorded the reasons for reaching that conclusion in the patient's clinical records and consent to be signed by parent or guardian. ☐
- I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead ☐

Signed (Podiatrist): ..... Date ..... /...../.....

Name (PRINT) .....

The SOCIETY of CHIROPODISTS & PODIATRISTS

Betafeet Podiatry

Medical History and Patient agreement to Podiatry Treatment

Patient's Surname ………................................ First name ………............................... Date of birth …….........................

Address …….

Post Code ..……………………………………... Occupation ……………………………… **Date** .... / .... / ....

Tel: ....………………………… Mobile …………………………………….. .. Email……………………………………..…

It is important that you answer these questions as honestly as possible to ensure you receive the best possible treatment. If you are not happy about any of the disclosure, please discuss this with your podiatrist, as these conditions or medications could have an effect when having an assessment or treatment.

1	Please provide name and contact number in case of emergency:	Yes/No
2	Are you on any medication (or have been in the last 6 months)? If yes, please specify.	Yes/No
3	Are you taking steroids (or have in the last 2 years)?	Yes/No
4	Any history of kidney or liver conditions? (Please state)	Yes/No
5	Have you ever had trouble with your heart? (Please state)	Yes/No
6	Have you ever had problems with your chest? (e.g. Asthma , COPD, other?)	Yes/No
7	Any allergies (e.g. hay fever, eczema, food, medications, dressings, latex)?	Yes/No
8	Do you suffer from high or low blood pressure?	Yes/No High/Low
9	Have you ever had Diabetes? (Please state) Type 1 or Type 2	Yes/No
10	Do you have a Thyroid Problem?	Yes/No
11	Do you have Arthritis - Rheumatoid or Osteoarthritis (Please state)	Yes/No
12	Have you ever injured or suffered from pain in the knees, hips or lower back? (Please state which)	Yes/No
13	Do you have or have you had Epilepsy?	Yes/No
14	Do you have fainting attacks or blackouts?	Yes/No
15	Have you had surgery or recently been in hospital? (Please specify in full)	Yes/No
16	Have/had any infections such as MRSA, TB, HIV, Hep B or C	Yes/No
17	Do you have any other medical conditions that we should be aware of? (please list)	Yes/No
18	Is there a history of illness in your family (e.g. heart disease, diabetes, cancer, other?)	Yes/No
19	Do you use Tobacco products?	Yes/No
20	Do you drink alcohol? How many units per week?	Yes/No
21	Do you have any eyesight or hearing difficulties? (Please state)	Yes/No
22	Please state your Shoe size and your weight:	
23	Has consent to treatment been signed?	Yes/No
24	Your GP name and address of surgery:	
25	How did you find out about us? Professional Referral (eg GP, Nurse, Carer, Health Care Professional) Please circle Friend/Family Passing Trade Internet Advert	

We collect key information about patients, their medical conditions and clinical care. This information is maintained electronically in our patient database on our computer systems. All information is held in accordance with the Principles of the Data Protection Act 1998 and all staff have a legal duty to maintain your confidentiality. **(Please turn over to sign agreement to treatment)**

Patient Medical History & Consent to Treatment Patient Name: DoB: