1. : CLIENT ASSESSMENT FORM AND RECORD SHEET

**(Name)……………………………….NAIL CARE SERVICE – Location Code ………..……..**

Name of Client…………………………………………………………………….…………

Patient with Diabetes (please delete as appropriate) …………………YES /NO

GP approval needed? ……YES/NO Date letter sent to GP for approval……/……/…..

Date response received from GP …./..…./…. Client Accepted for Nail Care: Yes/No

.

Reason if not accepted…………………………………………….…………………

|  |  |  |
| --- | --- | --- |
| Client’s unique service number: | Ethnic Code | Address:Post Code: |
| Prefers to be called: | Date of Birth…..……/…...…/………. |
|  Client’s telephone number:…………………………………. | Client’s mobile number……………………….... |
|  Name and telephone contact details for next of kin: | Lives alone: Yes/No | Emergency Contact Name and telephone number: (if different from Next of Kin): |

HEALTH INFORMATION – DO ANY OF THE FOLLOWING APPLY TO THE CLIENT?

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Have you ever had a foot ulcer? |  |  |
| Do you bleed excessively when you cut yourself? |  |  |
| Have you previously had footcare treatment if so please circle … NHS / Private |  |  |
| Are you taking Warfarin or any other Anti-coagulant ? |  |  |
| Do you have mobility problems? If yes please give details: |  |  |

Please tick each box to confirm the statements below:

The information above is correct.

I am happy for you to make contact with my GP, Dr………………………………..…

GP’s Address: ……………………………………… …………………………………….

GP’s Post code …………………… GP’s Phone Number ………………………..…….

I understand that this service is provided by …………………………..………… (Nail Carer) who is trained to cut nails. I understand that the service offered is not a Podiatry or Chiropody service (i.e. not a medical service) but a basic footcare service for which I will pay.

Client’s signature ……………………………………….Date……………………………….

Assessment carried out by (Name of Nail Carer) …………………...…………………….