**PODIATRY SERVICE MOBILITY QUESTIONNAIRE**

# The Podiatry Service provides a limited visiting service to patients who meet our criteria. Please READ the information leaflet “Podiatry Home Visiting service ” before completing this questionnaire.

Please consider attending your local clinic by using: public transport, taxi, and friend or families car, combine a clinic appointment with another trip such as shopping, doctors or hairdresser or use the Access bus to attend clinic when you are using it for shopping/leisure.

***PLEASE ANSWER ALL QUESTIONS***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | **NHS: DOB:** | | | |
|  | | | | | | |
| 1. **Why do you wish to be considered for a home visit?** | | | | | | |
|  | | | | | | |
| **2. Do you attend a day centre?** | | | | YES ❒ | | NO ❒ |
| **3. If you’ve answered ‘yes’ to question 2, which day centre do you attend, and on which days?** | | | | | | |
| **Day Centre Name:** | | | **Days:** | | | |
| 1. **Do you need to use any of the following walking / mobility aids?** | | | | | | |
| Frame | YES ❒ NO ❒ | Wheelchair | | | YES ❒ NO ❒ | |
| Sticks | YES ❒ NO ❒ | Motorised Scooter | | | YES ❒ NO ❒ | |
| If you use other mobility aids, please write these in the ‘further comments’ section. | | | | | | |
| **5. How do you get to the following?** | | | | | | |
| Doctor |  | | Dentist |  | | |
| Hairdresser/ Barber |  | | Optician |  | | |
| Shops |  | | Collect Pension |  | | |
|  | | | | | | |
| **6. Do you have access to a car?** | | | ONLY SOMETIMES ❒ | YES ❒ | | NO ❒ |
| **7. Do you need assistance getting in and out of a car?** | | | | YES ❒ | | NO ❒ |
| **8. Do you need to have an escort with you whenever you go out?** | | | | YES ❒ | | NO ❒ |
| **9. Do you use local taxis?** | | | | YES ❒ | | NO ❒ |
| **10. Do you use public transport?** | | | | YES ❒ | | NO ❒ |
| **11. Do you receive home care services?** | | | | YES ❒ | | NO ❒ |
| **12. Further Comments :** | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant’s Signature: |  | Date: |  |
| Name(Designations and Signature of referring healthcare professional and contact telephone number) | | | |

\* Please return this questionnaire **along with** the application for the podiatry service *(if applicable ie* ***new patient*** *accessing the service)* to the podiatrist at the local clinic/health centre.

\* If you do not meet our criteria for a home visit you will be informed of this decision.

\* If you have any specific queries or requirements please do not hesitate to contact our headquarters at: **Leeds Community Podiatry Services, Stockdale House, Victoria Road, Leeds, LS6 1PF**

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