

HCS Foot Care Referral Form

Date: _____

Referring MD: _____

Client: _____

DOB: _____

Client Contact Information: _____

They are being referred for the following reason(s):

☐ General Foot and Nail Care and Inspection

☐ Loss of Protective Sensation

☐ Limited Joint Mobility

☐ Nail Disease

☐ Other:

History: ☐ Diabetes ☐ PVD ☐ Tobacco Use ☐ Other:

Comments:

Specific MD Orders:

MD Signature:

Home Healthcare, Hospice & Community Services ~ Wellness Program
312 Marlboro Street, Keene NH
603-352-2253 ~ 1-800-541-4145
Fax: 603-242-1534

This referral form is solely for regular foot care and inspection at the HCS Foot Clinic. For more severe issues including foot ulcers, wound care, or any issue that needs more regular attention, please send a referral to the HCS VNA instead.