



Your Clinic Name Here
**Your Clinic Address, website, phone
number here**



Specializing in Medical Foot, Lower Limb & Wound Care Services

Patient's Name : _____ **DOB:** _____

Referral From : _____ **Date:** _____

**Medical Diagnosis (PCP) or PodOrtho™ Foot Specialist Diagnosis
and/or Assessment Findings**

Referral for:

Medical Foot Care

- ☐ General or Diabetic Foot Care & Screening
- ☐ Wound Care (Debride, Cleanse, Heal (PBMT), Dress, Off Load)
- ☐ Keratotic Disorders (corns, calluses, fissures, warts)
- ☐ Toenail Care (thick, dystrophic)
- ☐ Ingrown Toenail (removal, bracing, Tx. of local infection)
- ☐ Nail Infections (fungal, mold, parasitic, bacterial, viral)

Photobiomodulation Therapy (PBMT):

- ☐ Fore Foot Pain/Healing (neuroma, metatarsalgia, bunion)
- ☐ Mid Foot Pain/Healing (plantar fasciitis, rep. strains/sprains)
- ☐ Heel Pain/Healing (spur, repetitive/compressional stress)
- ☐ Diabetic Peripheral Neuropathy (nerve & circulation)
- ☐ Rapid Wound Healing (arterial, venous, diabetic, pressure ulcers)
- ☐ Knee/Ankle Pain
- ☐ Rapid Post Surgical Healing
- ☐ Leg Length Discrepancy

Lower Limb Care

- ☐ Custom Foot Orthotics
- ☐ Orthopedic Shoes
- ☐ Diabetic Shoes
- ☐ Digital Appliances (Orthoses)
- ☐ Braces
- ☐ L.L. Lymphatic Massage
- ☐ Registered Reflexology

Compression Therapy

- ☐ 15-20 mmHg
- ☐ 20-30 mmHg
- ☐ 30-40 mmHg
- ☐ Maternity
- ☐ Lymphedema

Physician/NP/Other RHCP Signature _____

Physician/NP/Other RHCP Reg. # _____