Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

For official use only.

Card No ....

Date issued ....

Renewed ....

....

COMMUNITY CARE AREA 1
Dublin Mid-Leinster
Tivoli Road
Dun Laoghaire

Tel: 284 3579

Date ....

APPLICATION FOR CHIROPODY TREATMENT

Only Persons over 65 eligible

Please complete Part 1 of this form and then bring the form to your doctor, who will complete Part 2 of the form if Chiropody treatment is necessary.

PART 1 **PARTICULARS TO BE FURNISHED BY APPLICANT**

Name ______________________ Date of Birth ______________

Address ____

____

Medical Card Number ______________ Review date of Medical Card ______________

Married/Single/Widow/Widower ______________

Name and Address of Chiropodist you wish to attend ______________________

____

Do you hold, or have you previously held an HSE Dublin Mid-Leinster Chiropody Card? __________

If YES, please state -

(a) Expiry date of Chiropody Card ______________ (b) Reg. No. of Chiropody Card __________

NOTE: *Persons requiring treatment will be referred only to Chiropodists on the panel.*
A list of Chiropodists on the panel may be had from this department on request.

PART 2 **PARTICULARS TO BE FURNISHED BY THE DOCTOR OR PUBLIC HEALTH NURSE**

(* Strike out whichever does not apply)

I certify that I have examined. ______________________________

*He / She IS / IS NOT in need of chiropody treatment.

*He / She is suffering from ______________________________

and is in need of Chiropody treatment.

Is the applicant able to travel to a Chiropodist? ______________

If not, please state reason why ______________________________

Signature of Doctor ______________________________

Address ______________________________

Date ______________________________

m38h/88