Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

For official use only.

Card No _____

Date Issued _____

Renewed _____

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 & Address of Chiropodist you wish to attend _____

_____

Do you hold, or have you previously held an HSE 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/Public Health Nurse _____

Address _____

Date _____

HSE Dublin South East, Community Services, Vergemount Hall, Clonskeagh, Dublin 6
Tel. 01 2680366 Fax 01 2830006