West Elgin Community Health Centre

Request for Chiropody (foot care) Services

153 Main St. Box 761
West Lorne, ON ~ N0L 2P0

Tel: 519-768-1715 **Fax: 519-768-2548**

Today's Date: _____ /_____ /_____ **Date of Birth:** _____ /_____ /_____
Day Month Year Day Month Year

Name: _____ / _____ / _____
First Middle Last Name As it appears on Health Card

Home Address: _____ _____ _____ _____
Box # **Apt.# or RR#** **House# or 911#** **Street Name**

_____ _____ _____
City / Town **Province** **Postal Code**

Preferred Phone #: _____ **Can we leave a message at this #:** ☐ Yes ☐ No

Alternate Phone #: _____ **Can we leave a message at this #:** ☐ Yes ☐ No

Nature of Foot Problem: *Please specify (Callus , corn, warts, thick toenails)*

Medical Conditions: *Please list*

Date Forwarded to Chiropodist : _____ Staff Signature_____

To be completed by Chiropodist:

☐ Book appointment ☐ Book 1 time appointment only ☐ More information required

Comments:

☐ Place on wait list - Notify patient of this.

Completed Date:_____ Staff signature: _____