|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CAIS AM ASESIAD**  **Podiatreg ac Orthoteg** | | | | | Dychwelwch i:  **Adran Podiatreg ac Orthoteg**  **Canolfan Gofal Integredig Aberteifi,**  **Rhodfa’r Felin,**  **Aberteifi**  **SA43 1JX Ffôn: 01239 801572** | | | | | |
| **Mae rheoli ffordd o fyw yn rhan o’n strategaeth driniaeth i gefnogi eich iechyd a gofal traed e.e. rhoi’r gorau i smygu, rheoli pwysau, ymarfer corff, cyngor ar esgidiau a hunan-ofal.**  **NID YDYM YN DARPARU**   * **Torri ewinedd traed normal, tew neu ffwngaidd (gofal ewinedd cymdeithasol)** * **Triniaeth i gleifion nad ydynt yn cydymffurfio** * **Ymweliadau cartref â chleifion nad ydynt yn gaeth i’r tŷ** | | | | | | | | | | |
| Teitl: | Enwau cyntaf: | | | | | Cyfenw: | | | | |
| Cyfeiriad: | | | | | | | | | | |
| Cod Post: | | | | | Dyddiad Geni: | | | | | |
| Rhif ffôn gartref: | | | | | Rhif ffôn yn ystod y dydd/Symudol: | | | | | |
| Meddyg: | | | | | Meddygfa: | | | | | |
| **Esboniwch pam yr ydych yn gwneud cais – rhowch gymaint o wybodaeth â phosib** (gall methu â gwneud hynny arwain at ddychwelyd eich ffurflen): | | | | | | | | | | |
| Cyflyrau Meddygol: | | | | Meddyginiaethau: | | | | | | |
| Alergeddau: | | | | | | | | | | |
| **Cyfeiriwyd gan** (claf/gweithiwr proffesiynol). **Printiwch eich enw a llofnodwch**: | | | | | | | Dyddiad: | | Ward/Ysbyty (os yn berthnasol): | |
| Dynodiad (os yn berthnasol): | | | | | | |
| **Defnydd swyddogol yn unig** | | | | | | | | | | |
| **Dyddiad cael y cais:** | | **Brysbennu:** | **Brys/Arferol:** | | | | | **Llofnod:** | | **Dyddiad:** |
| **APPLICATION FOR ASSESSMENT**  **Podiatry and Orthotics** | | | | | Please return to:  **Department of Podiatry and Orthotics**  **Cardigan Integrated Care Centre,**  **Rhodfa’r Felin,**  **Cardigan**  **SA43 1JX Tel :01239 801572** | | | | | |
| **Lifestyle management is part of our treatment strategy to support your health and footcare e.g. smoking cessation, weight management, exercise, footwear advice and self care.**  **WE DO NOT PROVIDE**   * **The cutting of normal, thickened or fungal toe nails (social nail care)** * **Treatment to non compliant patients** * **Home visits for patients who are not house bound** | | | | | | | | | | |
| Title: | First Names: | | | | | Surname: | | | | |
| Address: | | | | | | | | | | |
| Post Code: | | | | | DOB: | | | | | |
| Telephone Home: | | | | | Telephone Day/Mobile: | | | | | |
| Doctor: | | | | | GP Surgery: | | | | | |
| **Please explain why you are applying & give as much information as possible** (failure to do so may result in your form being returned): | | | | | | | | | | |
| Medical conditions: | | | | Medications: | | | | | | |
| Allergies: | | | | | | | | | | |
| **Referred by** (patient/professional). **Please print name and sign**: | | | | | | | Date: | | Ward/Hospital (if applicable): | |
| Designation (If applicable): | | | | | | |
| **Official use only** | | | | | | | | | | |
| **Date received:** | | **Triage:** | **Urgent/Routine** | | | | | **Signed:** | | **Date:** |