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| **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:** |