# BLUEWATER

## Foot & Ankle Specialists

Please fax patient demographics, insurance, and this form to (854) 444-3190

Referring Physician _____ Date _____

Patient Name _____ DOB _____

## Reason for Referral

- ☐ Diabetes
  - ☐ Foot Assessment
  - ☐ Nail Care
  - ☐ Neuropathy
  - ☐ Wound Care
  - ☐ Diabetic Shoes/Inserts
- ☐ Structural Deformity
  - ☐ Bunion(s)
  - ☐ Hammertoe(s)
  - ☐ Flat Feet
  - ☐ High-arched Feet
  - ☐ Custom Orthotics
- ☐ Traumatic Injury
  - ☐ Ankle
  - ☐ Midfoot / Forefoot
- ☐ Ingrown Toenail(s)
- ☐ Heel Pain
- ☐ Corns / Calluses / Warts
- ☐ Other _____

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