Local Health Office Dublin West
Cherry Orchard Hospital
Ballyfermot
Dublin 10

Tel: 620 6300

For official use only.

Card No .....

Date issued .....

Renewed .....

.....

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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 and 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_____

Address _____

Date _____