Bigfoot Podiatry, PLLC
Medical Orders

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support@bigfootpodiatrypllc.com

Please return this form to our fax number, email, or to the resident's facility.

Section A: Patient Information

Full Name: _____ Date of Birth: _____

Patient Address: _____

Facility Name: _____

Section B: Guarantor (Party responsible for scheduling appointments)

Full Name: _____ Relationship to Resident: _____

Email: _____ Phone Number: _____

Section C: Primary Care Provider

Full Name: _____

Fax: _____ Phone Number: _____

Section D: Referral for Treatment Purposes

The individual, Resident, and/or Guardian has requested podiatric services. Treatment with Bigfoot Podiatry, PLLC included but not limited to routine foot and nail care, callus debridement, ingrown toenail treatments, preventative foot care including offloading with pads and/or bracing, and treatments of other common podiatric foot and ankle pathologies, as needed. Appointments are scheduled for 15-60 minutes in length pending the complexity of the patient concerns and necessary medical attention. Appointments require the consent of the Individual or Guardian. Health Care Coordinator indicated in Section B will schedule the initial appointment and any follow up appointments. The primary care provider's signature in Section D authorizes Bigfoot Podiatry, PLLC to provide podiatric services references in this section.

Please complete the referral by circling yes or no on the following questions:

The patient is authorized to receive podiatric services as needed. **YES** **NO**

Comment: _____

The patient is currently on anti-coagulation therapy. **YES** **NO**

Comment: _____

Section D: Authorization for Treatment

Signature: _____ Date: _____

Primary Care Provider