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The Footcare CENTRE®
Berry Chiropody Professional Corporation

First name _____ Second name _____ Date of birth _____

Diagnosis _____

Reason for Referral:

- ☐ Foot Pain/Heel Pain
- ☐ Orthotics
- ☐ Foot care
- ☐ Fungal/Ingrown Toenail
- ☐ Other
- ☐ Plantar Wart or corn
- ☐ Diabetic Foot care
- ☐ Compression Hose ℞
  - Pairs ☐ prn ☐ Other
  - Freq ☐ prn ☐ Other
  - ☐ 20-30mmHg ☐ Calf
  - ☐ 30-40mmHg ☐ Thigh
  - ☐ 50-60mmHg ☐ Pantyhose

Physician signature _____ Physician _____

Phone _____ Date mm/dd/yy _____

The **care**, **professionalism** and **time** that your feet deserve