



Appendix N: Clinic Assessment Tool

The following is an example of an interprofessional assessment tool that may be used within a clinic setting.

Interprofessional Diabetes Foot Ulcer Team 310 Wellington Road, London N6C 4P4 Initial Assessment Form - Clinic		Date: _____																					
		Patient name: _____ Date of birth: _____																					
PRESENTING PROBLEM Site: _____ Duration (weeks): _____		Cause: _____ _____																					
PERIPHERAL VASCULAR SUPPLY																							
History of vascular symptoms: <input type="checkbox"/> None <input type="checkbox"/> Intermittent claudication <input type="checkbox"/> Rest pain <input type="checkbox"/> Insufficient activity to elicit symptoms <input type="checkbox"/> Edema <input type="checkbox"/> Previous hospitalizations for vascular specific issues Colour: <input type="checkbox"/> Normal <input type="checkbox"/> Cyanosis <input type="checkbox"/> Erythema <input type="checkbox"/> Pallor on limb elevation <input type="checkbox"/> Rubor on limb dependency <input type="checkbox"/> Mottling Temperature gradient: <input type="checkbox"/> Normal R/prox – distal _____ L/prox – distal _____ Pulses palpable (tick if yes) : Left foot: <input type="checkbox"/> DP <input type="checkbox"/> PT Right foot: <input type="checkbox"/> DP <input type="checkbox"/> PT <input type="checkbox"/> Vascular risk/PAD <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%; text-align: center;">PT</td> <td style="width: 12.5%; text-align: center;">DP</td> <td style="width: 12.5%; text-align: center;">PPG</td> <td style="width: 12.5%; text-align: center;">Brachial</td> <td style="width: 12.5%; text-align: center;">ABI</td> <td style="width: 12.5%; text-align: center;">TBI</td> </tr> <tr> <td style="border: 1px solid black;">R/F</td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> </tr> <tr> <td style="border: 1px solid black;">L/F</td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> </tr> </table>			PT	DP	PPG	Brachial	ABI	TBI	R/F							L/F							Capillary refill: R/great toe <input type="checkbox"/> <1sec <input type="checkbox"/> 1-3 sec <input type="checkbox"/> >3 sec L/great toe <input type="checkbox"/> <1sec <input type="checkbox"/> 1-3 sec <input type="checkbox"/> >3 sec Integumentary changes: <input type="checkbox"/> Normal <input type="checkbox"/> Skin atrophy <input type="checkbox"/> Abnormal wrinkling <input type="checkbox"/> Absence of hair growth <input type="checkbox"/> Nail growth abnormal: _____ <input type="checkbox"/> Dry gangrene Skin examination: Appearance (colour, texture, turgor, quality, dryness): _____ <input type="checkbox"/> Normal Presence of callus (discoloration/sub callus bleeding): _____ <input type="checkbox"/> Interdigital lesions <input type="checkbox"/> Tinea pedis <input type="checkbox"/> Other _____
	PT	DP	PPG	Brachial	ABI	TBI																	
R/F																							
L/F																							
REFERRAL CRITERIA FOR VASCULAR SURGERY CONSULT: <input type="checkbox"/> Foot ulcer <input type="checkbox"/> Pulses impalpable <input type="checkbox"/> ABI < 0.9; TBI < 0.6 Date contacted Dr. De Rose: _____ Next step: _____																							
Collected by Clinician: _____		Signed: _____																					
NEUROLOGICAL ASSESSMENT Sensory: Monofilament(10g, /4): L: _____ R: _____ Graduated Tuning Fork: L: _____ R: _____ <input type="checkbox"/> Neurological risk/LOPS Autonomic: <input type="checkbox"/> Normal <input type="checkbox"/> Dry scaly skin <input type="checkbox"/> Maceration between toes <input type="checkbox"/> Loss of hair growth <input type="checkbox"/> Thickened toenails Motor: <input type="checkbox"/> Normal Range of motion: tick if abnormal <input type="checkbox"/> Ankle <input type="checkbox"/> Sub talar joint <input type="checkbox"/> R/ 1 st ray <input type="checkbox"/> L/ 1 st ray <input type="checkbox"/> R/Big toe <input type="checkbox"/> L/Big toe <input type="checkbox"/> Other _____ Deep tendon reflexes: tick if absent <input type="checkbox"/> Normal <input type="checkbox"/> Patellar <input type="checkbox"/> Achilles		FOOTWEAR EXAMINATION: Type of shoe (athletic, oxford, comfort etc.): _____ Fit: _____ Depth of toe box: <input type="checkbox"/> Enough room for toes <input type="checkbox"/> Not enough depth _____ Shoe wear: _____ Lining wear: _____ Foreign bodies inside shoe: _____ Devices eg. orthotics: _____																					
		MUSCULOSKELETAL EXAMINATION: Biomechanical assessment: Clinician: _____ Signed: _____ Heel Contact: _____ Mid Stance: _____ Heel lift: _____ Toe off: _____ Description: _____																					

PATIENT NAME _____	Date: _____
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FOOT FUNCTION: <input type="checkbox"/> High foot pressures (>6kg/cm) <input type="checkbox"/> Limited joint mobility <input type="checkbox"/> Normal Foot deformity: <input type="checkbox"/> None <u>Muscle Group strength testing</u> (Passive, active, weight bearing and non-weight bearing) <input type="checkbox"/> Abnormalities: _____ <input type="checkbox"/> Nail: _____ <input type="checkbox"/> Joint: _____ <input type="checkbox"/> Prior amputation <input type="checkbox"/> Tendo-achilles contractures/equinus <input type="checkbox"/> Foot drop <input type="checkbox"/> Intrinsic muscle atrophy <input type="checkbox"/> Other _____	
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ULCER CLASSIFICATION: Neuropathic Neuroischemic Ischemic Other _____

Comments: _____

MENTAL/PSYCHOSOCIAL STATUS: Capable of Consent? Yes No

Are you currently experiencing any difficulties in your personal or family life (e.g., relationship problems, depression, eating disorder, or other health problems) that might interfere with your ability to manage your foot care?

During the past month. Have you often been bothered by feeling down, depressed or hopeless? YES NO

Have you often been bothered by little interest or pleasure in doing things? (note: "often" means almost every day) YES NO

If yes to either question refer to psychology

ULCER ASSESSMENT:

Location: _____

Length _____ cm Width _____ cm Depth _____ cm

Wound base:

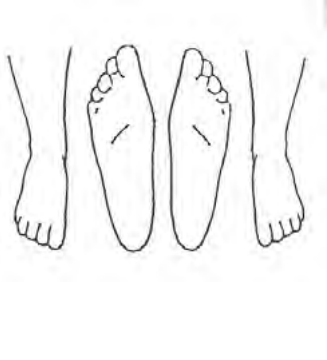
Granulation Tissue ____%; Necrotic (Slough/eschar) ____% Epithelium ____%

Necrotic tissue type (hard black, soft grey eschar, yellow slough): _____

Integrity of Granulation tissue (bright red, pale, friable, dull dusky red): _____

Edges (advancing, attached, not attached, rolled, fibrotic, callus): _____

Exudate: None Light Moderate Heavy



PAIN: Numerical Rating Scale (0 – 10): RF ____/10 LF ____/10

What triggers pain: _____

What soothes pain: _____

Location: _____

Describe: Sharp shooting dull, aching burning Other _____

WOUND TRACING

TEMPERATURES:

Location: _____	L _____ °C	R _____ °C	Diff: _____ °C
Location: _____	L _____ °C	R _____ °C	Diff: _____ °C
Location: _____	L _____ °C	R _____ °C	Diff: _____ °C
Location: _____	L _____ °C	R _____ °C	Diff: _____ °C

Clinician: _____ Signed: _____

PATIENT NAME	Date:
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SOFT TISSUE INFECTION: <input type="checkbox"/> No clinical signs or symptoms <input type="checkbox"/> Clinical signs and symptoms of mild (PEDIS level 2) infection: <input type="checkbox"/> Clinical signs and symptoms of moderate (PEDIS level 3) infection. <input type="checkbox"/> Severe (PEDIS level 4) infection	PEDIS WOUND CLASSIFICATION: P: Grade: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 E: Area: _____cm ² D: Grade: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 I: Grade: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 S: Grade: <input type="checkbox"/> 1 <input type="checkbox"/> 2
POTENTIAL FOR ULCER TO HEAL:	

TREATMENTS:

Cut and filed nails: _____

Debridement: _____

Other: _____

Clinician: _____ Signed: _____

Physiotherapist notes: Print name: _____ Signed: _____	Orthotist notes: Print name: _____ Signed: _____
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DRESSINGS: Primary: _____ Secondary: _____ Fixation: _____	FREQUENCY OF DRESSING CHANGES: <input type="checkbox"/> daily <input type="checkbox"/> every 2 nd day <input type="checkbox"/> twice a week <input type="checkbox"/> once a week DRESSINGS TO BE CHANGED BY: <input type="checkbox"/> patient <input type="checkbox"/> family member _____ <input type="checkbox"/> nurse
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PRESSURE REDISTRIBUTION: <input type="checkbox"/> Felt to foot: describe: _____ <input type="checkbox"/> Post op rocker sole slipper	<input type="checkbox"/> Walker. Type _____ <input type="checkbox"/> TCC <input type="checkbox"/> Other _____
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Clinician: _____ Signed: _____

Notes:

Clinician: _____ Signed: _____

INSTRUCTIONS GIVEN RE: WOUNDCARE Patient information brochure provided

Dressing changes Reducing weight bearing activity How to identify if infection develops & what to do
 Keeping wound dry Other _____

PATIENT NAME _____		Date: _____
REFERRALS: <input type="checkbox"/> Orthopaedic surgeon <input type="checkbox"/> Vascular Surgeon <input type="checkbox"/> Social Work <input type="checkbox"/> Psychology <input type="checkbox"/> CCAC for wound care <input type="checkbox"/> Other _____		
EDUCATION: _____		
CORRESPONDENCE: Family Physician: _____ Wound Nurse: _____ Other: _____ By clinician _____ Signed _____	FOLLOW-UP: <input type="checkbox"/> Next Available <input type="checkbox"/> ____ weeks <input type="checkbox"/> ____ months <input type="checkbox"/> PRN <input type="checkbox"/> D/C Notes: _____	
Clinician: _____ Signed: _____		

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