# Screening Form: Mobility assistive products

TAP

## 1. Information about the person

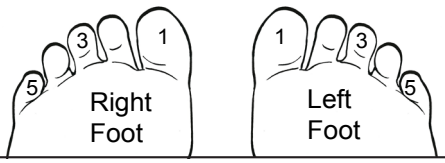
| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Family Name: | | | |
| Gender: | Male ☐ Female ☐ Other ☐ | Age: | 0-5 ☐ 6-18 ☐ 19-39 ☐ 40-54 ☐ 55+ ☐ | | |
| Telephone: | | Address: | | | |

## 2. Simple mobility and health risk check

| Ask the following questions | | | |
|---|---|---|---|
| **Loss of mobility** | Has your mobility reduced a lot in the past three months? | Yes ☐ ☞ Refer to health care service | No ☐ |
| **Children's mobility** | Is the child two years or more and not able to walk? | Yes ☐ ☞ Refer to rehabilitation service | No ☐ |
| **Risk of falling** | Do you worry about falling, or have you fallen more than once in the past year? | Yes ☐ → Provide assistive product ☞ Refer to rehabilitation service | No ☐ |
| **Pressure wounds** | Do you have a pressure wound on your body (such as hips, buttocks, back)? | Yes ☐ → Advise to avoid pressure on wound and ☞ refer to health care service for wound care | No ☐ |

| | | | |
|---|---|---|---|
| **Risk of foot wound** | Have you had: | Foot wound ☐ Amputation ☐ | If any → Complete foot screen below |
| | Do you have: | Foot wound, injury or swelling ☐ Diabetes ☐ Leprosy ☐ Heart and/or kidney disease ☐ If any → Check person is visiting health care service regularly. If not ☞ Refer. | |
| | Do you: | Smoke ☐ Drink alcohol (a lot) ☐ Often walk barefoot ☐ | |

## 3. Foot screen (complete if person answers yes to any risk of foot wound questions)

| Look closely at the top and bottom of the person's feet and between their toes | | |
|---|---|---|
| Has the person had before: | Foot wound ☐ A toe, foot or leg amputation ☐ | If any → High risk sign ☐ |
| Does the person have now: | A toe, foot or leg wound or injury ☐ | |
| Is either foot: | Red ☐ Hot to touch ☐ Swollen ☐ | |
| Can you see any: | Skin / nail problems ☐ Unusual shape of foot / toes ☐ | → Risk sign ☐ |
| **Check blood flow** | | |
| Can you see signs of reduced blood flow: | Ankle or foot swelling ☐ No hair on feet or toes ☐ Cold or pale foot ☐ | If any → Risk sign ☐ |
| **Ask**: Do you feel pain in the back of your legs? | At night ☐ While walking less than 200 metres ☐ | |
| **Pulse test** | **Left foot:** Top ☐ Ankle ☐ **Right foot:** Top ☐ Ankle ☐ | No pulse → Risk sign ☐ |
| **Refill test:** Push end of each big toe firmly. Count seconds for toe to return (refill) to normal colour. | Refill less than 3 secs ☐ | |
| | Refill more than 3 secs ☐ | → Risk sign ☐ |
| **Check feeling (sensation)** | | |
| **Ask**: Do you have any unusual feelings or pain in your feet or toes? | Yes ☐ | → Risk sign ☐ |
| **Sensation test**: With person's eyes closed - touch tip of toes 1, 3 and 5, switching to the other foot after each touch. ✓ Tick toes that feel ✕ Cross toes that do not feel |   | If person can't feel 2 or more toes → Risk sign ☐ |

☞ Referral recommended ✎ Write notes here

| Summarise the person's foot wound risk (count the number of risk and high-risk signs ticked) | | | |
|---|---|---|---|
| Number of risk signs ticked | | Level of foot wound risk | |
| Risk | High risk | | |
| 0 or 1 ☐ | 0 ☐ | Low ☐ | → Teach about suitable shoes<br>→ Teach how to care for feet |
| 2 ☐ | 0 ☐ | Moderate ☐ | → Teach how to care for feet<br>→ Assess for therapeutic footwear and/or<br>☞ Refer to health care service or foot wound clinic |
| 3+ ☐ | 1 ☐ | High ☐ | |

**4. Simple screening questions for mobility assistive products**

| Walking aid and/or wheelchair | | |
|---|---|---|
| Can you stand and walk? | Yes, without difficulty ☐ | No action |
| | Yes, with assistance ☐<br>Yes, only short distances ☐<br>Yes, on one leg only ☐ | If any → Assess for walking aid and discuss<br>☞ referral for wheelchair assessment |
| | No, cannot walk at all ☐ | ☞ Refer for wheelchair assessment |
| **Portable ramp (only for people who use a wheelchair, rollator or walking frame)** | | |
| Do you need to get up and down a few steps and/or in and out of a vehicle regularly? | Yes ☐ → A portable ramp may assist<br>No ☐ | |
| **Grab bar (for example in the bedroom, toilet, bathroom, or by steps)** | | |
| Do you have difficulty around your home moving in bed, balancing, sitting up, standing up or moving? | Yes ☐ → Grab bars may asssit<br>No ☐ | |
| **Transfer board (for example to move to and from the bed, toilet, sofa or vehicle)** | | |
| Do you have difficulty moving your body from one place to another? | Yes ☐ → A transfer board may assist<br>No ☐ | |
| **Prosthetic foot or leg (for people with a leg or foot amputation)** | | |
| Do you use a prosthesis? | Yes ☐ → Check prosthesis ☞ refer to prosthetics service if any concerns<br>No ☐ → Discuss if a referral to a prosthetic service is needed | |

**5. Other assistive products**

| | | |
|---|---|---|
| **Do you have difficulty with:** | Seeing ☐ Hearing ☐ Self care ☐<br>Communication ☐ Cognition (thinking / remembering) ☐ | If any → Other assistive products and/or ☞ referral to other services may be needed |

**6. Plan**

| | | |
|---|---|---|
| **Screen for:** | Seeing ☐ Hearing ☐ Self care ☐ Communication ☐ Cognition ☐ | |
| **Assess for:** | Walking aids ☐ Portable ramp ☐ Grab bars in the home ☐<br>Transfer board ☐ Therapeutic footwear ☐ | |
| **Teach about:** | How to care for feet ☐ Suitable shoes to wear ☐ | |
| **Refer to other service for:** | Health care ☐ Wound care ☐ Rehabilitation ☐ Wheelchair ☐<br>Diabetes care ☐ Foot wound clinic ☐ Prosthetic review or assessment ☐<br>Other: ✎ _____ | |
| **Follow up in:** | 1-3 months ☐ 6 months ☐ 12 months ☐ | **Follow up date:** ✎ _____ |

☞ Referral recommended ✎ Write notes here