

1. Information about the person

First name:		Family name:		Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Other <input type="checkbox"/>
Age:	0-5 <input type="checkbox"/>	6-18 <input type="checkbox"/>	19-39 <input type="checkbox"/>	40-54 <input type="checkbox"/>	55+ <input type="checkbox"/>	Telephone:	
Address:							

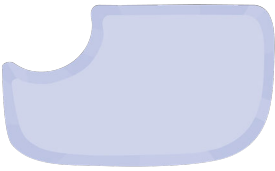
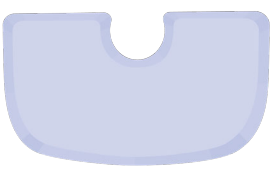
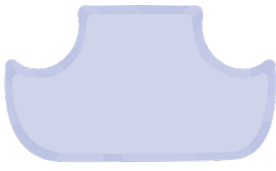

2. Referral information

Does the person have referral form from a health professional for an offloading product?	Yes <input type="checkbox"/>	If both yes → Continue assessment	No <input type="checkbox"/>	If either no ☞ Refer to health professional
Is the referral form complete?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Next wound review: ✍				

3. Assessment interview

Talk with the person			
Do you have difficulty with:	Seeing <input type="checkbox"/> Remembering <input type="checkbox"/> Self care <input type="checkbox"/>		If yes to any → Include carer in assessment and consider other assistive products and/or ☞ referral to other services
Risk of falling	Do you worry about falling, or have you fallen more than once in the past year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes → Consider if walking aid and/or more training is needed
Access and ability	Will you come for appointments every week?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no ☞ Contact referrer
	Will you be able to keep your foot dry?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no ☞ Check the offloading product selection table for suitable offloading product(s)
Footwear	Do you always wear shoes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no ☞ Assess for therapeutic footwear
	Do you have therapeutic footwear?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Check both feet and legs			
Infection	Observe: Are there signs of infection (red, hot, swollen, painful, wet dressing or yellow fluid)? Even if you can't see the wound, you may see signs of infection on the leg or foot.	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes ☞ Refer to health professional for infection management
Swelling	Ask: Do you have any problems with leg or foot swelling?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes to any → Check the offloading product selection table for suitable offloading product(s)
	Observe: Is there swelling now?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Skin problems	Ask: Do you ever get rashes or other skin problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Observe: Does the person have any rashes or skin problems now?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Observe: Is the skin wet, moist, dry or damaged? <i>Check foot and referral form. Do not remove dressing(s).</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Wound dressing	Observe: Does the person have a thin dressing on the wound?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no ☞ Refer for dressing change
	Observe: Is the dressing clean and dry?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

4. Action

Fit:	Rigid removable boot (RRB) <input type="checkbox"/>	Therapeutic footwear	Total contact cast <input type="checkbox"/>
	→ With felt padding <input type="checkbox"/>	→ With felt padding <input type="checkbox"/>	→ Cast shoe size: ✎ _____
			
	Single wing pad <input type="checkbox"/>	U Pad <input type="checkbox"/>	Double wing pad <input type="checkbox"/>
			
	Toe prop <input type="checkbox"/>		
Teach about:	Wearing at all times <input type="checkbox"/>	Checking for problems <input type="checkbox"/>	Looking after product <input type="checkbox"/>
	Follow up <input type="checkbox"/>		

5. Plan

Assess for:	Therapeutic footwear <input type="checkbox"/>	Walking aid <input type="checkbox"/>	Other: ✎ _____
Refer to other service for:	Wound care <input type="checkbox"/>	Diabetes care <input type="checkbox"/>	Rehabilitation <input type="checkbox"/>
	Orthosis <input type="checkbox"/>	Wheelchair <input type="checkbox"/>	Walking aid <input type="checkbox"/>
	Other: ✎ _____		
Follow up	3 days <input type="checkbox"/>	1 week <input type="checkbox"/>	2 weeks <input type="checkbox"/>
	Follow up date: ✎ _____		