## Assessment form: Offloading

### 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. Referral information

| Does the person have referral form from a health professional for an offloading product? | Yes ☐ | **If both yes** ⟶ Continue assessment | No ☐ | **If either no** ☞ Refer to health professional |
|---|---|---|---|---|
| Is the referral form complete? | Yes ☐ | | No ☐ | |
| Next wound review: ✎ | | | | |

### 3. Assessment interview

| **Talk with the person** | | | | |
|---|---|---|---|---|
| **Do you have difficulty with:** | Seeing ☐ Remembering ☐ Self care ☐ | | | **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 ☐ | No ☐ | **If yes** ⟶ Consider if walking aid and/or more training is needed |
| **Access and ability** | Will you come for appointments every week? | Yes ☐ | No ☐ | **If no** ☞ Contact referrer |
| | Will you be able to keep your foot dry? | Yes ☐ | No ☐ | **If no** ☞ Check the offloading product selection table for suitable offloading product(s) |
| **Footwear** | Do you always wear shoes? | Yes ☐ | No ☐ | **If no** ☞ Assess for therapeutic footwear |
| | Do you have therapeutic footwear? | Yes ☐ | No ☐ | |
| **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 ☐ | No ☐ | **If yes** ☞ Refer to health professional for infection management |
| **Swelling** | **Ask:** Do you have any problems with leg or foot swelling? | Yes ☐ | No ☐ | **If yes to any** ⟶ Check the offloading product selection table for suitable offloading product(s) |
| | **Observe:** Is there swelling now? | Yes ☐ | No ☐ | |
| **Skin problems** | **Ask:** Do you ever get rashes or other skin problems? | Yes ☐ | No ☐ | |
| | **Observe:** Does the person have any rashes or skin problems now? | Yes ☐ | No ☐ | |
| | **Observe:** Is the skin wet, moist, dry or damaged? *Check foot and referral form. Do **not** remove dressing(s).* | Yes ☐ | No ☐ | |
| | **Observe:** Is there callousing on bottom of either foot? *Callouses can increase pressure on the skin.* | Yes ☐ | No ☐ | **If yes** ☞ Refer for debridement to remove callous |
| **Wound dressing** | **Observe:** Does the person have a thin dressing on the wound? | Yes ☐ | No ☐ | **If no** ☞ Refer for dressing change |
| | **Observe:** Is the dressing clean and dry? | Yes ☐ | No ☐ | |

**4. Action**

| Fit: | Rigid removable boot (RRB) ☐<br>→ With felt padding ☐ | Therapeutic footwear<br>→ With felt padding ☐ | Total contact cast ☐<br>→ Cast shoe size: ✎_______ | |
|---|---|---|---|---|
| | Single wing pad ☐ | U Pad ☐ | Double wing pad ☐ | Toe prop ☐ |
| Teach about: | Wearing at all times ☐ | Checking for problems ☐ | Looking after product ☐ | Follow up ☐ |

**5. Plan**

| Assess for: | Therapeutic footwear ☐ Walking aid ☐ Other: ✎___________________ | |
|---|---|---|
| Refer to other service for: | Wound care ☐ Diabetes care ☐ Rehabilitation ☐ Orthosis ☐<br>Wheelchair ☐ Walking aid ☐ Other: ✎___________________ | |
| Follow up | 3 days ☐ 1 week ☐ 2 weeks ☐ | Follow up date: ✎ |