



MEDICAL RECORD
Diabetes Foot Assessment/
Action Plan
Front Page
Diabetes Education

Surname:

Given Names:

UR No:DOB:

(AFFIX PATIENT LABEL)

GENERAL FOOT CARE		Circle correct answer	
	Yes	No	
Feet clean	<input type="checkbox"/>	<input type="checkbox"/>	
Skin:			
Interdigital areas:			
Callus:			
Sock/hose clean well fitting	<input type="checkbox"/>	<input type="checkbox"/>	
Shoes appropriate	<input type="checkbox"/>	<input type="checkbox"/>	
Orthotics/prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	
Nails			
Thickened:			
Fungal infection:			
Ingrown:			

Right

Left



Right

Left

ASSESSMENT OF NEUROLOGICAL STATUS	
Pain:	
Burning, Numbness, pin & needles:	
Pressure of 5.07/10gm monofilament detected	
Indicate on diagram with ✓ if sensation present or ✗ if absent	



Right

Left

ASSESSMENT OF VASCULAR STATUS	Right		Left			Right		Left	
	Y	N	Y	N		Y	N	Y	N
Intermittent Claudication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dorsal pedis pulse present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pallor on elevation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Posterior tibial pulse present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amputation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair on feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gangrene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Capillary Return > 5 sec.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer present (if Yes describe):	Yes		No		Temperature of feet:				

ASSESSMENT OF SELF CARE CAPABILITY					
Feet adequately cared for	Yes	No	Understands the effects of diabetes on feet	Yes	No
Impaired Vision	Yes	No	Can identify appropriate foot care practices	Yes	No
Able to reach feet for safe self care	Yes	No	Complete Action Plan (reverse)		

Diabetes Foot Assessment



Medical Record Diabetes Foot Assessment/ Action Plan Back Page

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RISK CATEGORY**MANAGEMENT GUIDELINES****Low Risk Patient**

None of the five high risk characteristics below

Perform Annual comprehensive foot exam
Assess/ recommend appropriate foot wear
Provide education for preventive self care**Complete Action Plan****High Risk Patient**

One or more of the following:

 Symptoms of neuropathy Absent pedal pulses Foot deformity Current/History of foot ulcer Prior AmputationRefer to Podiatrist
Perform Visual inspection at every visit
Provide/demonstrate education for preventive self care
Assess /prescribe appropriate foot wear**Complete Action Plan*****Action Plan***

<u>Problem</u>	<u>Action Recommended</u>	<u>Details and Date(s) of Referral(s) / Education</u>
<input type="checkbox"/> Ulceration /signs of infection	Immediate referral to General Practitioner	
<input type="checkbox"/> High risk foot	Referred to Podiatrist Refer for medical assessment at least every six months Visual inspection at every visit	
<input type="checkbox"/> Active foot problem	Refer to Podiatrist and/or General Practitioner	
<input type="checkbox"/> Symptomatic Peripheral Vascular Disease	Refer to General Practitioner or Physician	
<input type="checkbox"/> Symptomatic Peripheral Neuropathy	Refer to General Practitioner or Physician	
<input type="checkbox"/> Foot deformity or abnormality	Referred to Podiatrist	
<input type="checkbox"/> Inadequate knowledge of foot care practices	Provide education	
<input type="checkbox"/> Inability to perform safe self care practices	Educate family member or carer	

Comments:

Diabetes Australia 'Footcare and Diabetes' handout provided

Yes

No

Name:

Date: