Diabetic Foot Care – Follow-up Form

This form is to be used for recording information during a follow up visit after wound healing.

motivation australia

Hospital number:		Date:	

Health personnel	
Follow up location:	NDC ☐ ECHC ☐ CHC ☐ Other _____

Information about the person

Name:					
DOB:		Age:		Male ☐ Female ☐ Other ☐ _____	
Address:				Phone:	

General physical condition (Nursing/Medical)

Height: _____ cm	Weight: _____ kg	Blood pressure: _____ mm Hg	Heart rate: _____ bpm

Stroke ☐ Frail old age ☐ Arthritis ☐ Regular falls ☐ Poor balance ☐

Fatigue ☐ Upper limb impairment ☐ Pain ☐ Other: _____

Amputation since last foot care appointment: Yes ☐ No ☐ Date of amputation: _____

Amputation level:								
	Toe Amputation	L ☐	R ☐		Transtibial	L ☐	R ☐	
	Partial foot amputation	L ☐	R ☐		Trans femoral	L ☐	R ☐	
					Other:_____	L ☐	R ☐	

Cause of amputation: Infection ☐ Ischaemia ☐ Charcot ☐ Other: _____

Diabetes specific (Nursing/Medical)

Diabetes Diagnosis date: _____

Diabetes diagnosis type: Type I ☐ Type II ☐ Gestational ☐ Unknown ☐ None ☐

Diabetes management: Diet controlled ☐ Insulin ☐ Diabetes Medication ☐ *type*: _____

Blood glucose level: _____ mmol/L Fasting ☐ / Non fasting ☐ HbA1C: _____ mmol/mol *(if available)*

Diabetes well controlled:	Yes ☐	No ☐	Smoker:	Yes ☐	No ☐	***Provide education***
Nutrition:	Good ☐	Poor ☐	Alcohol	Yes ☐	No ☐	

Lower limb observations and tests (team)

		Right foot	Left foot
Is sensation reduced on the foot/feet?		Yes ☐ No ☐	Yes ☐ No ☐
Is foot hot or swollen? *(if yes refer to medical team urgently)*		Yes ☐ No ☐	Yes ☐ No ☐
Blood supply:	Is there a dorsalis pedis pulse?	Yes ☐ No ☐	Yes ☐ No ☐
	Is there a posterior tibial pulse?	Yes ☐ No ☐	Yes ☐ No ☐

WARNING SIGNS: If the foot is hot, swollen or pulses are absent the foot may be infected, ischaemic or have charcot neuropathy. If suspected clients should be immediately referred to the medical team.

Visual inspection (team)			
Does the person have any of the following:			
• **A current foot wound?**	**Yes ☐** **Is the foot swollen, red, hot or is there a bad smell?**	**Yes ☐**	***Refer immediately** to ECHC or NDC*
		No ☐	***Manage wound** according to wound management guide.* *Complete new wound management form for any new wounds.*
	No ☐		
• Cracked skin on the foot? • Ingrown or long nails? • Moist skin between toes?	Yes ☐	*These can cause a wound. **Educate** about foot care.*	
	No ☐		
• Thick hardened skin *(callous)* on their feet?	Yes ☐	*This is a sign of increased pressure in a small area that can lead to a wound. **Refer** to ECHC (or NDC) for management.*	
	No ☐		

Foot, ankle and knee deformity (Orthotist/ Nurse)			
Is there a foot deformity? Yes ☐ No ☐			Claw toes: R ☐ L ☐
Hammer toes: R ☐ L ☐	Cavus deformity: R ☐ L ☐		Charcot deformity: R ☐ L ☐
Ankle deformity:		Knee deformity:	
Calcaneus (heel) varus: R ☐ L ☐		Knee varus: R ☐ L ☐	
Calcaneus (heel) valgus: R ☐ L ☐		Knee valgus: R ☐ L ☐	
Plantarflexion contracture: R ☐ L ☐		Other:	

Interview	
Does the person have any new health problems?	Yes ☐ No ☐
If yes – describe	
Does the person wear appropriate shoes?	Yes ☐ No ☐
If no – why not?	
Do they have any questions?	Yes ☐ No ☐
If yes – what questions. Is further training needed?	

Review of orthosis / offloading device/mobility device	
Is the person currently using an orthosis / offloading device?	Yes ☐ No ☐
Is the person currently using a mobility device (wheelchair, walking aid)	Yes ☐ No ☐
Does the person have any problems using the mobility or offloading device? (Is referral needed?)	Yes ☐ No ☐
If yes, what are the problems?	
Is the offloading or mobility device suitable for continued use?	Yes ☐ No ☐
If no – refer as needed or complete new prescription forms.	

Major activity on follow up

Basic foot care ☐	Management of new foot wound *(complete foot wound management form)* ☐
Modified existing offloading device ☐	New offloading device provided (complete new prescription form) ☐
Training/education ☐	Refer to another service ☐ _____
Other ☐_____	

Planning

Planned follow up date:	1 month ☐	2 months ☐	3 months ☐	Other:

Signatures

Client:		Health personnel:		Date:	