00Ct-feb 2011

NAME: ______________________________ DATE:______________

PHONE:_____________________________

DOB (d/m/y) / / Male / Female

RISK LEVEL:

0 – **No loss** of protective sensation, yet is diabetic.
1 – **Loss** of protective sensation.
2 – **Peripheral sensory neuropathy,** predisposing foot deformity.
3 – **History of pathology**, previous amputation/ulcer.
4 –**Active neuropathic ulceration,** charcot arthropathy.
5– **Severe active foot infection** of foot ulcer, foot deformity
6– **Severe, acute peripheral arterial disease.**

SOADI Diabetic Foot Assessment Form

Past Medical History (self report)

Diabetes:

Type 1 ☐ Type 2 ☐ Gestational ☐ Pre-Diabetic ☐

# of yrs, details:_________________________________

Chief Foot Complaint: ___________________________

____

Previous Foot Complications: ___________________

____

Medication:___________________________________

____

Foot wear : Appropriate Y☐ N☐

Describe:

____

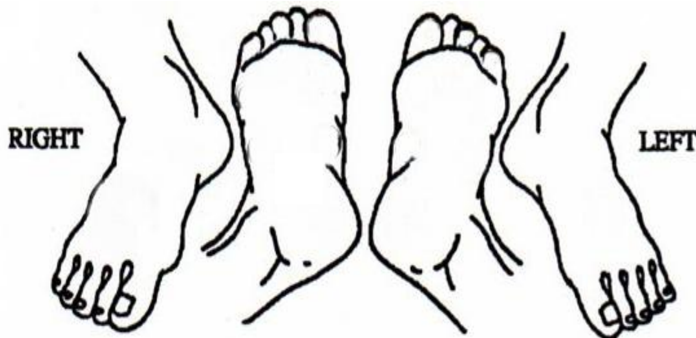
____

Sensation: Standard Monofilament 10 gm

Draw on image 1st, 3rd and 5th metatarsals and plantar aspect of the distal hallux:
Present (+) / Absent (-)

Foot Condition:

Draw on image:
S=swelling, **R**=redness, **T**=temperature, **P**=pain
▲ =callus, **M**=maceration,★ =pre-ulcer, ■=ulcer



Circulation:

Pedal Pulses Present (P) / Absent (A)

Posterior Tibial: L____ R____

Dorsalis Pedis: L____ R____

Nail Condition:

Foot Hygiene/Skin Condition:

Structural Abnormalities:

(Biomechanical/ Amputation)

Yes ☐ **NO** ☐

List:__________________________________

____

____

____

____

Self Care Knowledge, mobility:

	Ability to inspect feet daily.
	Knowledge about appropriate footwear & Care
	Ability to perform routine foot care (visually and physically)

Education given Y☐ N☐

Details:

____

____

Assessment Details and Notes:

____

____

____

____

____

____

Return Foot Exams Y☐ N☐

please circle: (yearly/ monthly/ other)

SOADI's goal is to help prevent diabetic foot complications through education, screening and promoting ownership on **selfcare**. If follow up is required when self care is not sufficient based on foot condition, you will be given a SOADI Subsidy Application. It is the responsibility of the Participant to contact SOADI and service Providers for follow up care.

Participant Signature:

_________________________ Date: __________

Chiropodist Signature:

_________________________ Date:__________

SOADI HEAD OFFICE
8 CLAIRMONT STREET, UNIT 2, THOROLD ON, L2V 1R1
TEL: 905 938 2915, OR 1 888 514 1370 · FAX: 1 866-352-0485
www.soadifootcare.ca