Saskatchewan Lower Extremity Wound Pathway
LOWER LEG ASSESSMENT FORM

Client info:

Date of assessment:
Location of assessment:

SOCIAL HISTORY:

Occupation: __________________________________
Lives: ☐ alone ☐ with spouse ☐ long term care
☐ with family (specify): _______________________
☐ other (specify): ____________________________
Mobility: ☐ Independent ☐ Use of aid(s)__________
☐ Bed/chair bound ☐ Assistance from other person

HISTORY OF LEG ULCERS:

Previous history of leg ulcers ☐ Yes ☐ No
If yes: Year of first occurrence ___________________
Date of onset of current ulcer: ___________________
Location: ____________________________________
Previous use of compression bandages/stockings ☐ Yes ☐ No
Age of stockings: _____________________________

HEALTH HISTORY that may be associated with vascular disease

☐ No pertinent history ☐ Rest pain/night pain
☐ Family history of leg ulcers ☐ Lower extremity arterial disease
☐ Varicose veins ☐ Intermittent claudication
☐ Deep vein thrombosis affected leg ☐ Angina
☐ Deep vein thrombosis unaffected leg ☐ Hypertension diagnosis
☐ Venous surgery ☐ Heart failure
☐ Injection sclerotherapy ☐ Myocardial infarction
☐ Trauma/Fracture of leg(s) ☐ Past Smoker: Quit When? _______
☐ Pulmonary embolism ☐ Current smoker: # cigarettes/day: __________
☐ Pregnanacies # _____ ☐ Vascular surgery lower limbs: Location ______________________________
☐ Osteoarthritis ☐ Amputation (specify location)

MEDICATIONS:

Medication prescribed for leg/foot pain? ☐ Don’t know ☐ No ☐ Yes (specify):
Other medications ☐ see attached list/PIP ☐ review medication reconciliation form

Allergies (latex, ointments, medications) ☐ No ☐ Yes (describe):

LOWER LEG ASSESSMENT: (Mark all appropriate boxes)

<table>
<thead>
<tr>
<th>Signs of Venous Disease</th>
<th>Signs of Arterial/Ischemic</th>
<th>Signs of Diabetic/Neuropathic</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEMP</td>
<td>R L</td>
<td>Warm (may be cool with edema)</td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COLOUR</td>
<td>R L</td>
<td>Hemosiderin staining (brown staining)</td>
</tr>
<tr>
<td>COLOUR</td>
<td>R L</td>
<td>Dependent rubor</td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAIN</td>
<td>R L</td>
<td>Heavy, aching legs</td>
</tr>
<tr>
<td>PAIN</td>
<td>R L</td>
<td>Nocturnal pain</td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAIN</td>
<td>R L</td>
<td>With deep palpation</td>
</tr>
<tr>
<td>PAIN</td>
<td>R L</td>
<td>Knife-like pain</td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAIN</td>
<td>R L</td>
<td>Relieved by:</td>
</tr>
<tr>
<td>PAIN</td>
<td>R L</td>
<td>Pain at rest/legs elevated</td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAIN</td>
<td>R L</td>
<td>Intermittent claudication</td>
</tr>
<tr>
<td>PAIN</td>
<td>R L</td>
<td>Calf/leg/gluteal pain when walking</td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>R L</td>
<td>How far can client walk without pain:</td>
</tr>
</tbody>
</table>

Pain scale: 0-1-2-3-4-5-6-7-8-9-10

Saskatchewan Lower Extremity Wound Pathway – Lower Leg Assessment Form
# Saskatchewan Lower Extremity Wound Pathway
## LOWER LEG ASSESSMENT FORM

### Client info:

### Signs of Venous Disease
- Atrophie Blanche
- Lipodermatosclerosis (Woody fibrosis)
- Champagne bottle leg
- Ankle Flare
- Stasis dermatitis
- Venous eczema

### Signs of Arterial/Ischemic
- Shiny, thin skin
- Loss of hair growth
- Thickened nails
- Eschar (describe): __________

### Signs of Diabetic/Neuropathic
- No sweating in feet
- Excessive sweating in feet
- Xerosis (Cracks, fissures)
- Hyperkeratosis (callus)

### SKIN/NAIL

<table>
<thead>
<tr>
<th>Side</th>
<th>Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Atrophie Blanche</td>
</tr>
<tr>
<td>L</td>
<td>Lipodermatosclerosis</td>
</tr>
<tr>
<td></td>
<td>(Woody fibrosis)</td>
</tr>
<tr>
<td>R</td>
<td>Champagne bottle leg</td>
</tr>
<tr>
<td>L</td>
<td>Ankle Flare</td>
</tr>
<tr>
<td>R</td>
<td>Stasis dermatitis</td>
</tr>
<tr>
<td>L</td>
<td>Venous eczema</td>
</tr>
</tbody>
</table>

### Capillary Refill
- R L 3 seconds or less
- R L Greater than 3 seconds
- Capillary refill time: R ____ L ____

### Pulses
- R L Palpable Dorsalis Pedis (DP)
- R L Palpable Posterior tibial (PT)
- R L Diminished or absent DP
- R L Diminished or absent PT
- R L Bounding pulses DP
- R L Bounding pulses PT

### Wound Location
- R L Gaiter Area (lower 1/3 of calf)
- R L Comment: __________
- R L Foot
- R L Digits/toes
- R L Beneath Callus/plantar
- R L Bony prominences

### Probable Etiology:
- Venous
- Arterial/Ischemic
- Diabetic/Neuropathic
- Mixed
- Atypical

### EDEMA DISTRIBUTION
- R L Foot
- R L Up to Ankle
- R L Up to mid-calf
- R L Up to knee
- R L Up to groin
- R L No visible edema

### EDEMA SEVERITY
- Non-pitting
- Pitting
- Brawny induration/edema

### CIRCUMFERENCE MEASUREMENTS (CM)
- Calf: widest circumference ______ cm up from heel
- Ankle: 2.5 cm above malleoli

### Positive stemmer’s sign
- Consider decongestive therapy referral for significant, unresolved lymphedema.

### FOOT ASSESSMENT
- R L Bunion(s)
- R L Callus(s)
- R L Corn(s)
- R L Dropped metatarsal head(s)
- R L Hammertoe(s)
- R L Crossed toes
- R L Fissures
- R L Cracks between toes
- R L High arch/instep (Pes cavus)
- R L Abnormal skin dryness
- R L Acute Charcot presentation
- R L Chronic Charcot presentation
- R L Blister(s) location:
- R L Other
- R L Incorrect length - short
- R L Incorrect length - long
- R L Ingrown/involuted
- R L Thickened
- R L Discolored
- R L Ridded/Brittle
- R L Diagnosed fungal infection

### Range of Motion ANKLE
- R L Decreased

### Range of Motion KNEE
- R L Decreased

### Range of Motion GREAT TOE
- R L Decreased/Halux rigidus (stiff toe)
## Saskatchewan Lower Extremity Wound Pathway

### LOWER LEG ASSESSMENT FORM

#### Client info:

#### FOOTWEAR

<table>
<thead>
<tr>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthotics/offloading footwear</td>
<td>Evidence of wear/pressure points in footwear</td>
<td>Shoes not worn at all times in/outdoor</td>
<td>Poorly fitting/improper footwear</td>
<td>Areas of foot exposed to repetitive trauma</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

#### PULSE (Doppler):

- **Dorsalis Pedis (DP):**
  - Present
  - Diminished
  - Not audible
  - Triphasic
  - Biphasic
  - Monophasic

- **Posterior Tibial (PT):**
  - Present
  - Diminished
  - Not audible
  - Triphasic
  - Biphasic
  - Monophasic

#### SENSATION: Monofilament Test (10g)

- **Dorsum**
  - Right:
  - Left:
  - Score right: /10
  - Score left: /10

#### CIRCULATION:

- **Unable to compress arteries**

**Ankle brachial pressure index:** (ABPI) = highest systolic ankle pressure (DP or PT) divided by the highest systolic brachial pressure (left or right)

<table>
<thead>
<tr>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right brachial pressure:</td>
<td>Left brachial pressure:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right ankle pressure: DP</td>
<td>Left ankle pressure: DP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PT</td>
<td>PT</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Right ABPI score**
  - Left ABPI score

**Toe brachial pressure index:** (TBPI) = highest systolic toe pressure divided by the highest systolic brachial pressure (left or right)

- **Right toe pressure**
- **Left toe pressure**

- **Right TBPI score**
- **Left TBPI score**

#### PSYCHOSOCIAL CONSIDERATIONS:

Wound(s) affects:
- ☐ quality of life
- ☐ ability to work
- ☐ interactions with family/friends
- ☐ mental health
- ☐ other

**Comments:**

#### PREVIOUS PROFESSIONAL REFERRALS:

- ☐ Podiatry
- ☐ Orthotist
- ☐ OT/PT
- ☐ Other certified fitter
- ☐ Diabetes educator
- ☐ Home Care
- ☐ Dietitian
- ☐ Wound clinician nurse
- ☐ Social work
- ☐ Community programs
- ☐ Other certified fitter
- ☐ Social work
- ☐ Other certified fitter

**Score right:** /10

**Score left:** /10
**Infection in diabetic foot wounds:** Infection needs to be recognized and treated early as it can rapidly become limb threatening. **If any of these signs/symptoms are present contact the wound clinician nurse and family physician/NP.**

<table>
<thead>
<tr>
<th>Sign/Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Greater than 2 cm of redness</td>
</tr>
<tr>
<td>□ Foul odor</td>
</tr>
<tr>
<td>□ Wound breakdown</td>
</tr>
<tr>
<td>□ Local inflammatory response (warmth, swelling)</td>
</tr>
<tr>
<td>□ Probe to bone</td>
</tr>
<tr>
<td>□ Friable granulation tissue</td>
</tr>
<tr>
<td>□ Increased amount of exudate</td>
</tr>
</tbody>
</table>

*Notes:*

2. Lipsky et al. 2012 Infectious Diseases Society of America Clinical Practice Guideline for the Diagnosis and Treatment of Diabetic Foot Infections,
3. Botros et al. Best Practice Recommendations for the Prevention, Diagnosis and Treatment of Diabetic Foot Ulcers: Update 2010,

**Localized infection:** If 3 or more signs/symptoms are present add a topical antimicrobial contact layer to the wound dressing and contact the wound clinician nurse.

<table>
<thead>
<tr>
<th>Sign/Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Delayed wound healing</td>
</tr>
<tr>
<td>□ Fiable (bleeds easily)</td>
</tr>
<tr>
<td>□ Hypergranulation (raised, deep/bright red, friable) tissue</td>
</tr>
<tr>
<td>□ Epithelial bridging and granulation tissue pocketing</td>
</tr>
<tr>
<td>□ New areas of necrotic slough (yellow/grey/cream colored tissue)</td>
</tr>
<tr>
<td>□ Increased peri wound warmth</td>
</tr>
<tr>
<td>□ Increased wound size and/or development of sinus tracts and/or satellite wounds next to the original wound</td>
</tr>
<tr>
<td>□ Odour after wound cleansing</td>
</tr>
<tr>
<td>□ Increased wound size and/or development of sinus tracts and/or satellite wounds next to the original wound</td>
</tr>
<tr>
<td>□ New or increased Pain</td>
</tr>
</tbody>
</table>

**Classic signs of local infection:** If 3 or more signs/symptoms are present add a topical antimicrobial contact layer to the wound dressing and contact the most responsible provider for microbiological direction.

<table>
<thead>
<tr>
<th>Sign/Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Peri wound induration (firm edema) greater than/equal to 2cm</td>
</tr>
<tr>
<td>□ Peri wound erythema (redness) greater than/equal to 2cm</td>
</tr>
<tr>
<td>□ Increased peri wound warmth</td>
</tr>
<tr>
<td>□ Increased wound size and/or development of sinus tracts and/or satellite wounds next to the original wound</td>
</tr>
<tr>
<td>□ Purulent exudate (thickened, greenish or yellow/white fluid)</td>
</tr>
<tr>
<td>□ Onset of wound pain or increasing pain</td>
</tr>
</tbody>
</table>

**Spreading infection:** If any of these signs/symptoms are present contact the most responsible provider for review of the patient immediately or activate EMS. Systemic infection leads to septic shock and potentially multi organ failure.

<table>
<thead>
<tr>
<th>Sign/Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Lethargy/general feeling of being unwell</td>
</tr>
<tr>
<td>□ Fever (may be muted in clients who are elderly or immunocompromised)</td>
</tr>
<tr>
<td>□ Change in behaviour or cognition (especially in elderly clients)</td>
</tr>
<tr>
<td>□ Rigor / chills</td>
</tr>
<tr>
<td>□ Crepitus</td>
</tr>
<tr>
<td>□ Unexplained high blood sugar (in clients who are diabetic)</td>
</tr>
<tr>
<td>□ Increased swelling and tissue turgor (induration +/- redness)</td>
</tr>
<tr>
<td>□ Swollen lymph glands</td>
</tr>
<tr>
<td>□ Wound breakdown with or without satellite lesions</td>
</tr>
</tbody>
</table>

**Date (dd/mm/yy)  Time  Signature, Designation  Printed Name**

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